

OLDER AMERICANS ACT: HEALTH PROMOTION AND OTHER UNFUNDED TITLE III PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN SERVICES

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JUNE 11, 1990, ROCHESTER, NY

Comm. Pub. No. 101-771

Printed for the use of the Select Committee on Aging



U.S. GOVERNMENT PRINTING OFFICE

32-877

WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H141-27.

SELECT COMMITTEE ON AGING

EDWARD R. ROYBAL, California, *Chairman*

THOMAS J. DOWNEY, New York
 HAROLD E. FORD, Tennessee
 WILLIAM J. HUGHES, New Jersey
 MARILYN LLOYD, Tennessee
 MARY ROSE OAKAR, Ohio
 THOMAS A. LUKEN, Ohio
 BEVERLY B. BYRON, Maryland
 HENRY A. WAXMAN, California
 MIKE SYNAR, Oklahoma
 BUTLER DERRICK, South Carolina
 BRUCE F. VENTO, Minnesota
 BARNEY FRANK, Massachusetts
 TOM LANTOS, California
 RON WYDEN, Oregon
 GEO. W. CROCKETT, Jr., Michigan
 IKE SKELTON, Missouri
 DENNIS M. HERTEL, Michigan
 ROBERT A. BORSKI, Pennsylvania
 BEN ERDREICH, Alabama
 NORMAN SISISKY, Virginia
 ROBERT E. WISE, Jr., West Virginia
 BILL RICHARDSON, New Mexico
 HAROLD L. VOLKMER, Missouri
 BART GORDON, Tennessee
 THOMAS J. MANTON, New York
 RICHARD H. STALLINGS, Idaho
 JAMES McCLURE CLARKE, North Carolina
 JOSEPH P. KENNEDY II, Massachusetts
 LOUISE M. SLAUGHTER, New York
 JAMES H. BILBRAY, Nevada
 JIM JONTZ, Indiana
 JERRY F. COSTELLO, Illinois
 HARLEY O. STAGGERS, Jr., West Virginia
 FRANK PALLONE, Jr., New Jersey
 JOLENE UNSOELD, Washington
 PETER A. DeFAZIO, Oregon
 JOHN LEWIS, Georgia
 WAYNE OWENS, Utah

MATTHEW J. RINALDO, New Jersey,
Ranking Minority Member
 JOHN PAUL HAMMERSCHMIDT, Arkansas
 RALPH REGULA, Ohio
 NORMAN D. SHUMWAY, California
 OLYMPIA J. SNOWE, Maine
 THOMAS J. TAUKE, Iowa
 JIM COURTER, New Jersey
 CLAUDINE SCHNEIDER, Rhode Island
 THOMAS J. RIDGE, Pennsylvania
 CHRISTOPHER H. SMITH, New Jersey
 SHERWOOD L. BOEHLERT, New York
 JIM SAXTON, New Jersey
 HELEN DELICH BENTLEY, Maryland
 JIM LIGHTFOOT, Iowa
 HARRIS W. FAWELL, Illinois
 JAN MEYERS, Kansas
 BEN BLAZ, Guam
 PAUL B. HENRY, Michigan
 BILL SCHUETTE, Michigan
 FLOYD SPENCE, South Carolina
 WILLIAM F. CLINGER, Jr., Pennsylvania
 CONSTANCE A. MORELLA, Maryland
 PATRICIA F. SAIKI, Hawaii
 JOHN EDWARD PORTER, Illinois
 JOHN J. DUNCAN, Jr., Tennessee
 CLIFF STEARNS, Florida
 CRAIG T. JAMES, Florida

RICHARD A. VELOZ, M.P.H., J.D., *Staff Director*
 PAUL SCHLEGEL, *Minority Staff Director*

SUBCOMMITTEE ON HUMAN SERVICES

THOMAS J. DOWNEY, New York, *Chairman*

WILLIAM J. HUGHES, New Jersey
 TOM LANTOS, California
 BILL RICHARDSON, New Mexico
 JAMES McCLURE CLARKE, North Carolina
 JOSEPH P. KENNEDY II, Massachusetts
 LOUISE M. SLAUGHTER, New York
 HARLEY O. STAGGERS, Jr., West Virginia
 FRANK PALLONE, Jr., New Jersey
 PETER A. DeFAZIO, Oregon
 JOHN LEWIS, Georgia
 EDWARD R. ROYBAL, California,
 (Ex Officio)

OLYMPIA J. SNOWE, Maine,
Ranking Minority Member
 NORMAN D. SHUMWAY, California
 BEN BLAZ, Guam
 FLOYD SPENCE, South Carolina
 WILLIAM F. CLINGER, Jr., Pennsylvania
 CONSTANCE A. MORELLA, Maryland
 PATRICIA F. SAIKI, Hawaii
 JOHN J. DUNCAN, Jr., Tennessee
 MATTHEW J. RINALDO, New Jersey,
 (Ex Officio)

JOHN P. OLINGER, *Staff Director*
 NATALIE CANNON, *Minority Staff Director*

CONTENTS

MEMBERS' OPENING STATEMENTS

	Page
Chairman Thomas J. Downey	1
Louise M. Slaughter	2

CHRONOLOGICAL LIST OF WITNESSES

MORNING SESSION

Jack Skvorak, President and CEO, Regional Council on Aging, Inc., Rochester, New York	5
Sheldon Jaffee, Deputy Director for Federal Relations, New York State Office for the Aging	22
Margaret Williams, President, National Association of Area Agencies on Aging	39
Panel One—Consumer Perspective:	
Florence Carpenter, Gray Panthers	50
Julian "Jim" Bielski, Client, Elder Abuse Prevention Program, Regional Council on Aging	57
Joyce Shearer, Client, Long Term Care Ombudsman Program, testimony to be presented by Sharon Boyd, Long Term Care Ombudsman Program of the Regional Council on Aging	59
John Armbruster, Health Advocate, Monroe County Office for the Aging	61
Mary Boddie, Motion Promotion Program, Monroe County Office for the Aging	69
Panel Two—Provider Perspective:	
Sharon S. Boyd, Director, Monroe County Long Term Care Ombudsman Program, Regional Council on Aging	70
Thelma Nemeroff, Director, Elder Abuse Prevention Program, Regional Council on Aging	77
Connie Boyd, Director, Genesee County Office for the Aging	79
Marguerite Nickel, Community Health Nurse, Monroe County Health Department, Monroe Community Hospital, Alzheimer's Family Outreach Program	84
Teresa A. Galbier, Director, Developmentally Disabled Elderly Program, Regional Council on Aging	89
Pat Campbell, R.N., Nurse Consultant, Monroe County Office for the Aging	91
Joanne Greene, Counselor, Elder Counseling Program, Catholic Family Center	97

AFTERNOON SESSION

Marta Bermudez, St. Mary's Health Screening Program, St. Mary's Hospital	98
Joseph Morelle, Assistant Majority Leader, Monroe County Legislature	103

APPENDIX

Additional material received for the record:	
Assemblyman Paul Harenberg, Chairman, Assembly Standing Committee on Aging, New York State Legislature, prepared statement	123
Jane G. Gould, Director, New York State Office for the Aging, letter and attachment	125

IV

	Page
Katherine J. Lewis, Administrator, Monroe County Office for the Aging, prepared statement.....	136
Gay M. Pollack, Director, Long-Term Care, Finger Lakes Long Term Care Insurance Co., prepared statement.....	138
William B. Forsyth, M.D., Fairport, NY, prepared statement.....	150

THE OLDER AMERICANS ACT: HEALTH PROMOTION AND OTHER UNFUNDED TITLE III PROGRAMS

MONDAY, JUNE 11, 1990

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HUMAN SERVICES,
Washington, DC.

The subcommittee met, pursuant to notice at 9:30 a.m., at the Regional Council on Aging, 79 North Clinton Avenue, Rochester, New York, Hon. Tom Downey (chairman of the subcommittee) presiding.

Members present: Representatives Downey and Slaughter.

Staff present: John Olinger, Majority Staff Director; Moya Benoit, Majority Research Director; Linda Donahue, Nancy Alinger and Edward Fennessy, Aides to Representative Slaughter.

OPENING STATEMENT OF CHAIRMAN THOMAS J. DOWNEY

Mr. DOWNEY. Good morning. As the Chairman of the Subcommittee on Human Services of the Select Committee on Aging, I am very pleased to convene today's hearing. I would like to congratulate my colleague, Louise Slaughter, for calling this important hearing, as well as for welcoming me warmly to Rochester.

This hearing is one of a series of hearings being held by the Subcommittee on Human Services in advance of the 1991 reauthorization of the Older Americans Act. Today's hearing focuses on a very important part of the Older Americans Act, the underfunded programs of Title III. The result of today's hearing will be critical to the subcommittee as we prepare Congress for reauthorization, and I would like to thank all witnesses here today in advance for their testimony.

During the last reauthorization of the Older Americans Act, which took place in 1987, six new and important authorizations, aimed at specific target groups in the elderly population, were added. These authorizations were nonmedical in-home service for the frail elderly; a long-term care ombudsman program; assistance for special needs; health education and promotion; elder abuse prevention activities; and outreach services for older persons eligible for supplemental security income, better known as SSI; food stamps and Medicaid programs.

Today, we are placing special emphasis on the health education and promotion provision, which as many of you know, was introduced by Congresswoman Slaughter during the 1987 reauthoriza-

tion. The health education and promotion authorization is to be used to support routine health screening, physical and mental health services, nutritional programs and basic information and referral services relating to the specific health needs of the elderly. These vital services would be administered by State and area agencies on aging, whose job it would be to reach out to as many elderly as possible. It is important at this time to note that many State and area agencies already have programs like this in place, but are providing these services with existing funds and finding it harder and harder to stretch their dollars. The importance of this provision cannot be overemphasized. If our Nation's elderly are to avoid unnecessary institutionalization, the preventive health measures must be taken now.

Unfortunately, this provision, along with several others, has never been funded by Congress. At the time the Older Americans Act Amendments of 1987 were passed, these authorizations were subject to an appropriations trigger, which meant that funds were not to be appropriated to support these activities, unless total appropriations for Older Americans Act programs exceeded the previous year's level by 5 percent. Sadly, this 5 percent level has never been reached.

Earlier this year, both Louise and I presented testimony before the Subcommittee on Labor, HHH and Education of the House Appropriations Committee requesting that funding be appropriated for the unfunded programs of the Older Americans Act. And we will continue to work toward that end, and we will need to continue to build support, beginning with those of you here today. All of us must realize the fiscal constraints we face as we try to reduce the budget deficit and meet our commitment to maintain services to those who desperately need them.

The Older Americans Act, like most social programs, has not escaped the rigors of the Gramm-Rudman process and has felt a strain in all of its programs. Providers have had to do more with less and have had to cut services and change programs to make up the difference. Many come up with innovative ideas to supplement the funds they received. This is nothing new, and many of you will probably be testifying to that fact.

It is, as I said at the outset, a pleasure to be here with Louise, and I will turn the microphone over her to make a presentation.

STATEMENT OF REPRESENTATIVE LOUISE M. SLAUGHTER

Ms. SLAUGHTER. Thank you, Tom. Good morning. It is a great pleasure to have Tom here, first, because he is one of the shining lights of the Congress, and second, it is an equal pleasure for me to show all of you off. I think the things that we do in this community are probably the best in the country, and it will do Tom a world of good to see for himself the work that we do. I am really pleased to have all of you here. Thank you for coming and for the testimony you have worked so hard to prepare.

Tom Downey has shown great leadership in looking ahead already to the 1991 reauthorization of the Older Americans Act and in urging President Bush to call for a 1991 White House Conference on the Aging. Many of you have received copies of the letters

that we had sent over to the White House. Both of those efforts underscore the Chairman's commitment to a thorough consideration of senior citizens' needs, and I am grateful to him for this opportunity to present the views of my constituents to the House Select Committee on Aging.

Twenty-five years ago when the Older Americans Act became law, Congress made a promise to senior citizens that the Federal Government would help them overcome individual and social barriers to health maintenance, to economic independence and personal dignity. As we celebrate the act's silver anniversary, we celebrate 25 years of great achievement. The programs provided under the act meet some of the senior citizens' most basic needs for nutrition, transportation and even companionship. Certainly, this is not too much to give to older Americans who have enriched our Nation's history, lend meaning to the present day and give promise to our future.

Today's senior citizens have defended the Nation's freedom and kept alive for posterity the traditional American values. Who could deny this deserving population? The 30th Congressional District is home to some 58,000 senior citizens, and Rochester has a proud history of meeting their needs and looking out for their interests. Indeed, one of the first things I did when I got to Capitol Hill in 1987 was seek an appointment to the Select Committee on Aging because I recognized that the Rochester experience with programs and services for senior citizens would prove a valuable model for study by the Congress.

As we begin to think about reauthorization of the Older Americans Act, I know that the Rochester experience will provide useful insight into the strengths and weaknesses of the act, and that is why we have called this hearing today.

A cursory glance at the dollar figures from the last 10 years reveals a disappointing Federal commitment to funding the Older Americans Act. Notwithstanding this, the Older Americans Act is not a story of disappointment, but one of great achievement and promise, especially here in the Rochester area. Despite frozen funding levels, the counties of Monroe, Genesee, Livingston and Ontario have demonstrated a remarkable commitment to funding the important programs authorized, but not funded by Congress under Title III.

Those of us who have had the pleasure of living in this area for so long have always known that Rochester is a leader in many fields. And topping that list is the way in which we are able to meet the needs of our aging population. I hope Chairman Downey will forgive us, then, if we show off a little here today.

The Rochester area service organizations have created dozens of innovative programs for the elderly, and the seniors here have many opportunities—exercise classes, mental health programs, nutritional counseling, respite for caregivers and ombudsman services. In Rochester, we are lucky. In many places across the country, important programs which improve the quality of life and help the aging maintain independence and dignity do not exist at all. While the Rochester area service providers do a remarkable job of making these programs available, funding constraints exist so that not all senior residents have access to services.

I am sure we will hear from witnesses today that without Federal dollars, local programs are unable to provide the necessary staffing, transportation and outreach to serve all those who need their services. The problems our senior citizens face today will only be exacerbated in the coming decades. The growing numbers of elderly, rising health care and prescription drug costs, and increasing long-term care needs are already challenging the existing service-delivery infrastructure. As senior citizens seek to protect themselves from these trends, they often go too far and end up with shoe boxes full of costly, duplicative and worthless health insurance policies. They can be confused by the denial of claims and unsure of what Medicare covers. They worry about losing their homes or being unable to care for a beloved spouse. They dread living alone. These are just the types of problems which the Older Americans Act can help to solve.

As the elderly population continues to grow, the Older Americans Act is a promise that we cannot afford to break. Just like Social Security, millions of senior citizens have come to depend on the Older Americans Act, and we must not let either suffer because of the budget deficit.

While we are here today talking about Federal promises and commitments to senior citizens, I want to go on record as saying that senior citizens should not have to shoulder the burden of the deficit. Social Security is a promise that we intend to keep. And the Older Americans Act is a promise we intend to keep. Federal funding for that act has remained stagnant for too long.

I look forward to going back to Washington armed with the testimony presented here today and ready to fight for increased funding for the Older Americans Act. The Rochester experience makes the most eloquent argument that the Older Americans Act does dramatically improve the quality of life for some of America's most vulnerable citizens, and we need to make sure that it can continue to do so.

Before we begin, let me take this opportunity again to thank Congressman Downey for his commitment to the Older Americans Act and for coming to Rochester here today to see how it is implemented locally. I also want to recognize our witnesses, who have spent considerable time preparing testimony for today's hearing. Finally, I thank the members of my Long-Term Care Advisory Committee and its Chair, Sally Trafton, for their work in organizing this hearing. And I also want to say how much I appreciate the work my staff has done. Thank you.

Mr. DOWNEY. Thank you, Louise. I want to thank your staff and mine and also all of you who are here. As I mentioned at the beginning, part of the reason we do this—take the subcommittee on the road is to learn from you, and there is also a selfish reason. It is good to get out of Washington. And it is also exciting for us to see that there are as many people as there are in this country committed to helping others. It is energizing to see you all.

And to begin that process of energization, Jack Skvorak, who is the Director of the Regional Council on Aging, is going to offer us a welcome. Jack.

**STATEMENT OF JACK SKVORAK, PRESIDENT AND CEO,
REGIONAL COUNCIL ON AGING, INC., ROCHESTER, NEW YORK**

Mr. SKVORAK. Chairman Downey, Congresswoman Slaughter. I am very pleased to have the privilege of welcoming you to the Regional Council on Aging today for several reasons. First, we were deeply honored to have a Congressional hearing not only in Rochester, but here at the Regional Council on Aging. Secondly, the topic of the Older Americans Act, as you can imagine, is near and dear to our hearts. Even if we did not have the opportunity to testify, we would be very supportive of any meeting for that purpose.

And finally, it gives me great pleasure to know that so many of our staff have been recognized for their expertise in the field of aging and judged worthy contributors to this subject.

I also welcome very warmly the Representative for the New York State Office for the Aging, Sheldon Jaffee; Ms. Margaret Williams, who is the President of the National Association of Area Agencies on Aging; and the many other experts who have come to testify or merely to listen today.

We at the Regional Council on Aging have put together for your consideration today a rather comprehensive presentation on various areas of aging needs and services. Some of the authors of this information will have the opportunity to speak to you directly; others will only be able to present written testimony.

In general, we feel that the Older Americans Act has given notice to the people of this country that the needs of the elderly of our society are among the most important concerns for us to address.

Rochester and Monroe County are quite typical of cities and counties in the United States in terms of the percentage of its residents who are over the age of 60. Similarly, we too, find here that the 85 and older age group is the fastest growing segment of our population. We are in the midst of a 20-year period during which the 85 and older people will almost double in numbers. Yet as a rule, we find that funding sources for the aging struggle to keep pace with inflation, to say nothing of keeping up with the rapidly growing need.

About 2 years ago, the Regional Council on Aging moved into this building with the goal of complementing our over 20 programs with as many additional services for the aging from other agencies as possible. Other service providers now offer or soon will offer from this same location rather extensive health care services, legal services, financial management and advocacy. We rank with the best nationally in terms of the comprehensive array of programs and services we are able to offer under one roof.

The Super Center, or one-stop shopping for the aging, is a concept which is worth promoting in the renewed Older Americans Act to acknowledge the difficulty of many older people in need of assistance accessing services which are scattered about any given community.

A second major change in the act should be a more realistic look at how we are going to pay for the rapidly increasing needs of the elderly. There are three recommendations I offer for your consideration.

One, a top priority for programs to be promoted must be employment services and other self-help opportunities to keep our aging citizens as independent as possible for as long as possible. The dollars spent here will often save many more government funds from other sources.

Two, it is an empty gesture to speak about essential programs for the aging when corresponding funds are not allocated along with the verbal commitment. Long-term care ombudsman, elder abuse prevention and developmentally disabled elderly programs are a few examples of where that is currently happening, and you will hear more about that later.

Three, we must face the issue of fee-for-services squarely. The Federal, State and local governments have been clear recently in saying that they cannot meet the agreed upon needs of the aging with the declining resources at their disposal. For those who are near the poverty level, we must find the resources to meet their needs adequately. On the other hand, we must charge a fee for the services required by those who are able to pay, even if that is on a pro-rated basis. This is an issue which must be addressed now.

Some needs have developed over the years without a corresponding acknowledgment by those who fund the related services. Seniors have been practically left out of appropriate methods of treatment for mental health, alcohol and drug problems. This must be addressed immediately with specialized programs to meet their unique needs.

We at the Regional Council on Aging are starting to do research into the projected incidence of alcohol and drug abuse among the elderly and comparing that with the number receiving any form of treatment. Early indications show a low level of service compared with very significant needs.

Senior centers are now the major focal points which are recognized in the aging network. They warrant continued support, but we must recognize natural gathering points more, such as supermarkets, shopping malls and restaurants, at least to dispense information about available programs.

Nonmedical home support programs, which are volunteer driven, must become a high priority in the Older Americans Act. Quality of life is generally higher for people cared for at home than in institutions.

There are many needed changes, most of which require a commitment from our Congressional leaders to use the peace dividend for our senior citizens' security. If you make only one change in the Older Americans Act, the realistic need is for a relatively simple fee-for-service requirement for those who can afford it.

I look forward to listening along with you, Congresspeople Downey and Slaughter, to the experts who will now speak to the various aspects of the Older Americans Act.

Mr. DOWNEY. Thank you, Jim.

[The "Renewal of the Older Americans Act," testimony given by the staff of the Regional Council on Aging, Inc., follows:]

**RENEWAL OF THE OLDER AMERICANS ACT
TESTIMONY BEFORE
THE CONGRESSIONAL HEARING
JUNE 11, 1990**

**TESTIMONY GIVEN BY STAFF OF
REGIONAL COUNCIL ON AGING, INC.**

**BEFORE
CONGRESSWOMAN LOUISE SLAUGHTER
CONGRESSMAN THOMAS DOWNEY**

**HELD AT THE REGIONAL COUNCIL ON AGING,
79 NORTH CLINTON AVENUE
ROCHESTER, NEW YORK 14604
— (716) 454-3224**

**CONGRESSIONAL TESTIMONY ON
RENEWAL OF THE OLDER AMERICANS ACT
BY STAFF OF THE REGIONAL COUNCIL ON AGING, INC.**

**79 NORTH CLINTON AVENUE
ROCHESTER, NEW YORK 14604**

WELCOME AND OVERVIEW

**John G. Skvorak
President/CEO**

**OLDER ADULTS WITH DEVELOPMENTAL
DISABILITIES**

**Teresa Galbier, Director
Developmentally Disabled
Elderly Program**

ELDER ABUSE PREVENTION

**Thelma Nemeroff, Director
Elder Abuse Prevention
Program**

LONG TERM CARE OMBUDSMAN

**Sharon Boyd, Director
Advocacy Dept.**

SENIOR CENTERS

**Gary Shaw, Director
Garson Meyer Senior
Center**

SENIOR VOLUNTEERS

**Lorraine Anderson, Director
Retired Senior Volunteer
Program**

EMPLOYING THE OLDER WORKER

**Nyla Gaylord, Vice President
Employment Services
(GROW)**

IN-HOME SUPPORT SERVICES

**Debra Sponable, Director
Home Help for Seniors
Program**

WELCOME FROM REGIONAL COUNCIL ON AGING

I'm very pleased to have the privilege of welcoming you to the Regional Council on Aging today for several reasons. First, we're deeply honored to have a Congressional Hearing, not only in Rochester, but here at the Regional Council on Aging. Welcome Congresswoman Slaughter and Congressman Downey.

Secondly, the topic of the Older American Act, as you can imagine, is near and dear to our hearts. Even if we didn't have the opportunity to testify we would be very supportive of any meeting for that purpose.

And finally it gives me great pleasure to know that so many of our staff are recognized for their expertise in the field of aging and thought to be worthy contributors to this subject.

I also welcome very warmly the Assemblyman Paul Harenberg from the New York State Assembly Committee on the Aging; the representative from the New York State Office for the Aging, Sheldon Jaffee; Ms. Margaret Williams, who is the President of the National Association of Area Agencies on Aging; and the many other experts who have come to testify or merely to listen today.

We, at the Regional Council on Aging, have put together, for your consideration today, a rather comprehensive presentation on various areas of aging needs and services. Some of the authors of this information will have the opportunity to speak to you directly; others will only be able to present written testimony.

In general we feel that the Older Americans Act has given notice to the people of this country that the needs of the elderly of our society are among the most important concerns for us to address.

Rochester and Monroe County are quite typical of cities and counties in the United States in terms of the percentage of its residents who are over the age of 60. Similarly, we too find that the 85 and older group is the fastest growing segment of our population. We are in the midst of a 20 year period during which the 85 and older people will almost double in numbers. Yet, as a rule, we find that funding sources for the aging struggle to keep pace with inflation.

About two years ago the Regional Council on Aging moved into programs as many additional services for the aging from other agencies as possible.

Other service providers now offer (or soon will offer) from this same location rather extensive health care services, legal

Continued Next Page

WELCOME FROM REGIONAL COUNCIL ON AGING

services, financial management and advocacy. We rank with the best nationally in terms of the comprehensive array of programs and services we are able to offer under one roof.

The Super Center, or one stop shopping for the aging, is a concept which is worth promoting in the renewed Older Americans Act to acknowledge the difficulty many older people in need of assistance have in accessing services which are scattered about any given community.

A second major change in the Act should be a more realistic look at how we are going to pay for the rapidly increasing needs of the elderly. There are three recommendations I offer for your consideration:

- 1) A top priority for programs to be promoted must be employment services and other self-help opportunities to keep our aging citizens as independent as possible for as long as possible. The dollars spent here will often save many more government funds from other sources.
- 2) It's an empty gesture to speak about important programs for the aging when corresponding funds are not allocated along with the verbal commitment. Long term care ombudsman, elder abuse prevention and developmentally disabled elderly programs are a few examples of where that is currently happening.
- 3) We must face the issue of fee-for-services squarely. The federal, state and local governments have been clear recently in saying that they cannot meet the agreed upon needs of the aging with the declining resources at their disposal. For those who are near the poverty level we must find the resources to meet their needs adequately. On the other hand we must charge a fee for the services required by those who are able to pay, even if that is on a pro-rated basis. We can kid ourselves on this issue no longer.

Some needs have developed over the years without a corresponding acknowledgment by those who fund the related services. Seniors have been practically left out of appropriate methods of treatment for mental health, alcohol and drug problems. This must be addressed quickly with specialized programs to meet their unique needs.

We're starting to do research into the projected incidence of alcohol and drug abuse among the elderly and comparing that with the number receiving any form of treatment. Early indications show a low level of service compared with the needs.

REGIONAL COUNCIL ON AGING, INC. June 11, 1990
Rochester, New York 14604

John G. Skvorak
President/CEO

SUBJECT: OLDER ADULTS WITH DEVELOPMENTAL DISABILITIES

National trends show that the life expectancy of persons with Developmental Disabilities (DD) is increasing. This means that special programs to address their unique needs must be developed by agencies serving the aging population. We, at the Regional Council on Aging, feel fortunate to have a model program which has successfully met the needs of thirty-one older adults with DD in the past two and one-half years by providing comprehensive case management services so that they can successfully integrate into the existing senior services network with minimal supervision.

Current statistics show that there are at least 12,700 older persons with DD (aged 60 and up) in New York State; with at least four times as many estimated to be unknown to the DD system. There are an additional 7,200 who are aged 45-59 in New York State's DD registry alone.

Older person with DD, who are generally in the lower level income range, suffer from the lack of social services and day care programs. Because of the trigger mechanism in the Older Americans Act there is stiff resistance to increasing government spending on age based social services. The older population with DD is a segment of the elderly population facing the greatest need and receiving little or no targeted assistance under the Older Americans Act. Also, in-home support and respite services for families are necessary to avoid the costly alternative of institutionalization.

Eligibility for services is generally limited to persons age 60 and over. The Older Americans Act must recognize persons with Down's Syndrome as aging at a much faster rate than the normal population. A working definition of the older DD population must be developed by the Act. Special provisions must be made to include persons with premature aging in the definition of the older or aging population with DD. There is evidence that persons with mental retardation begin to decline in behavioral capacities during their fifties (Puccio, P., Janicki, M., Otis, J. and Rettig, J., 1983); incidence and onset of Alzheimer's Disease is shown to occur earlier among persons with Down's Syndrome (Lott, I. and Lai, F., 1982); and persons with mental retardation have a shorter life span when compared to the general population (Eyman, R., Grossman, H., Tarjan, G., and Miller, C., 1987).

There are numerous real life examples we can cite to back up any of our points and recommendations. One example includes an older woman with severe mental retardation who, because of the collaboration of Regional Council on Aging's Long Term Care Ombudsman Program, Developmentally Disabled Elderly Program, and several other human service agencies in the community is now participating in a community based senior center with the aid of a senior companion. In summary there are three important recommendations regarding the reauthorization of the Older Americans Act as related to individuals with DD.

Continued Next Page

SUBJECT: OLDER ADULTS WITH DEVELOPMENTAL DISABILITIES

These recommendations are:

1. The Older Americans Act must recognize special populations such as those with Down's Syndrome and mental retardation as aging faster than the normal population so that entitlement to the Older Americans Act for this population is at least at age fifty (50).
2. Integration of older adults with DD into existing senior services must be recognized as an integral part of the continuum of services for the older population. Adequate funding must be made available to provide training and workshops to staff of Older Americans Act programs to sensitize and educate them to the needs of the older adults with DD.
3. Adequate funding must flow so that additional staffing and support services can be provided for integration of older adults with DD to take place. In a cooperative program such as ours this can amount to as little as \$4,000 per senior center per year.

REFERENCES

Eyman, R., Grossman, H., Tarjan, G., and Miller C. (1987). *Life Expectancy and Mental Retardation: A Longitudinal Study in a State Residential Facility*. Washington, D. C.: American Association of Mental Deficiency.

Lott, I. and Lai, F. (1982). *Dementia in Down's Syndrome: Observations from a Neurology Clinic*. *Applied Research in Mental Retardation*, 3, 233-240.

Puccio, P., Janicki, M., Otis, J. and Rettig, J. (1983). *Report of the Committee on Aging and Developmental Disabilities*. New York: New York State Office of Mental Retardation and Developmental Disabilities.

REGIONAL COUNCIL ON AGING, INC. June 11, 1990 Teresa Galbier
Rochester, New York 14604 Director, Dev.
Disabled Elderly Prog.

SUBJECT: ELDER ABUSE PREVENTION

The current national estimate of elder abuse is set at approximately 4% of the population over age 60. This means that there is in excess of 5,000 elderly people in the Greater Rochester area being neglected, financially exploited or abused physically, verbally or psychologically.

Statistics further conjecture that only one out of eight victims of abuse become known to the community. This means that seven out of eight elderly who are mistreated are invisible and not receiving help. How do we reach them?

I believe New York State is mounting a major media blitz to inform the public about elder abuse and the danger signs about which we should be alert.

I applaud this new action and anticipate that an informed public will bring new cases of elder abuse to our attention.

My question is -- Will there be adequate resources in the community to extend help to clients and families in crisis?

The resources we need to do battle against elder abuse are:

- * competent, caring staff people
- * nursing home beds when necessary
- * good, reliable aide service
- * respite care, support groups
- * transportation for clients

I want to address the current status of these "resources" now.

ACCESS TO NURSING HOME BEDS

At the present time, we cannot, without great difficulty, access nursing home beds for Medicaid clients on an emergency basis; the waiting period is usually one to two years. If the Medicaid client has Alzheimer's disease or other dementia, the job is even more difficult.

AIDE SERVICE

Families who are under great stress or who are abusive need good, reliable aide service to support them in caring for an impaired older person. Unfortunately, especially if the client is on Medicaid, aide service may not be either good or reliable. Medicaid does not pay a high enough rate to attract well-trained, reliable aides.

RESPIRE CARE

Respite care, particularly for elder abuse clients, can make a difference. Families who receive respite from our staff get specially trained and supervised people. They not only offer

Continued Next Page

SUBJECT: ELDER ABUSE PREVENTION**RESPIRE CARE** (Continued)

leisure time for the caregiver, but also serve as role models for interaction with the disabled client. They have made a difference for families. However, our \$21,000 grant ends as of September 30, 1990. What will happen to these families who are at-risk for neglect and abuse when we can no longer serve them?

SUPPORT GROUPS AND TRANSPORTATION

Support groups provide an opportunity for people to share their concerns, practical solutions, and frustrations. However, without transportation and respite care available, some of the most isolated and needy caregivers cannot attend. Our project provides this service currently. Who will provide it after our State funding ends in December, 1990? Will the County of Monroe, under serious budget constraints themselves, be able to meet this very serious need?

COMPETENT, CARING STAFF

Elder abuse prevention begins and ends with skilled, caring staff people. This is a necessity when accessing services for clients-at-risk and working with families who are dysfunctional or in crisis.

Funding for Elder Abuse Prevention is essential for all the reasons mentioned above. It is not enough to have the public alerted to the signs of elder abuse or to institute mandatory reporting. Once abuse is uncovered, we must be prepared to act in a responsible way, with the resources necessary to provide the best interventions. Without resources we are as helpless as are the victims we are trying to serve.

REGIONAL COUNCIL ON AGING, INC. June 11, 1990 Thelma Hemeroff
Rochester, New York 14604 Director Elder Abuse Prevention

SUBJECT: SENIOR CENTERS

Among the first social organizations formed to serve older persons was the senior citizen center. They have always been places where older people could look forward to a good time, meeting friends, and involvement in meaningful activities. A senior center seeks to create an atmosphere that acknowledges the value of human life, individually and collectively, and affirms the dignity and self-worth of the older adult. The philosophy of the senior center movement is based on the premises that aging is a normal developmental process; that human beings need peers with whom they can interact and who are available as a source of encouragement and support, and that adults have the right to have a voice in determining matters in which they have a vital interest.

In 1972, Congress created the Nutrition Program for the Elderly as Title VII of the Older Americans Act (now Title III-C). The Nutrition Program was always meant to be more than just a meal. Its purpose is to nourish the whole person. Highest priority must be given to those who are in greatest need of nutrition, social contact and supportive services. However, as the elderly population continues to change, senior centers have evolved from mainly nutrition and recreational centers to multi-purpose entities offering a range of services. In an effort to meet the altered needs of older adults, senior centers are in a process of conversion which will present programmatic and fiscal choices to government officials and senior directors.

Some New York State statistics highlight the need for increased senior services. New York's elderly population is the second largest in the nation; approximately 13.1% of the State's total population is over 62 years of age; by the year 2030 the percentage of people 62 and over in New York State will be 25% of the total population. The national scene presents a similar picture.

In order to insure the future of senior centers as community resource facilities which can address the needs of a wide variety of seniors certain issues must be addressed and resolved quickly.

1. Lack of funds continues to be a major impediment. New funding streams need to be identified in order to continue quality programs.
2. Also, a senior center clearinghouse needs to be established in order to coordinate useful information.
3. Lack of transportation to and from senior centers is a major problem threatening center utilization.
4. Lastly, training programs for senior center staff need to be established as centers change and serve a diverse elderly population.

For many seniors in a given community the senior center becomes their second home - a place to learn, to volunteer, to share friendships, to eat, to enjoy life. There is nothing on the horizon to replace senior centers. Our task must be to adapt, change and improve them.

REGIONAL COUNCIL ON AGING, INC.
Rochester, New York 14604

June 11, 1990

Gary Shaw
Sr. Center Dir.

SUBJECT: LONG TERM CARE OMBUDSMAN

The rapidly aging population in our country (as well as the world), particularly among the old-old, makes long term care one of the most crucial issues for Congressional concern.

An advocate to assure quality long term care becomes essential.

The 1987 amendment to the Older American Act addressed this concern part way; it added separate authorization for appropriation to support long term care ombudsman services. However, it made the authorization subject to the trigger mechanism, making the program a second class citizen. If there's anything left in the pot the ombudsman programs may get it.

Since 1978 the Regional Council on Aging in Rochester, New York, has operated a long term care ombudsman program. Unfortunately, the program is funded for fewer staff than several years ago due to overall funding constraints.

One staff person, at 36 hours a week, and twenty-seven volunteer ombudsmen in the past year

- made 3,777 client contacts
- served 2,994 unduplicated program participants in 34 separate facilities
- and handled 406 community based complaints or requests for information

Unfortunately this doesn't adequately address the need because for every Long Term Care consumer in a facility there are four (4) others needing the same level of care who are at home. Here may be where the greatest advocacy is required.

Recommended changes

1. Long Term Care advocacy is too important to leave it to possible funding if there is an increase of more than 5% over the previous year's Older American Act funding level.
2. Long Term Care advocacy must be expanded with adequate funding to cover hospital and home care.

REGIONAL COUNCIL ON AGING, INC.
Rochester, New York 14604

June 11, 1990

Sharon Boyd
Director,
Advocacy Department

SUBJECT: SENIOR VOLUNTEERS

One objective identified in Title I of the Older Americans Act of 1965, as amended, is to secure for Older Americans the "pursuit of meaningful activity with a range of choices." Through ACTION, the Federal Volunteer Agency, a variety of Older American Volunteer Programs (OAVP) were established. In 1973, the Retired Senior Volunteer Program (RSVP) became one of them.

Currently, 750 RSVP projects across the country support 400,000 senior volunteers, 60 years of age and older, as they pursue "meaningful volunteer opportunities" through service to their communities. The volunteers contribute 73 million hours of service each year, averaging five (5) hours per week.

The participants serve without compensation, but transportation and other out-of-pocket expenses may be reimbursed. Two out of three RSVP volunteers are over age 70; 77% are female; 14% are minorities; nearly half have limited incomes.

Often older Americans are seen as being only the recipients of entitlements and services, rather than continuing to be productive members of society. RSVP dispels this myth by providing seniors the opportunity to remain active and to "give something back" to the community.

Our volunteers do so at a variety of sites, such as schools, hospitals, nursing homes, museums, senior centers, and other health care agencies. The range of positions available is almost limitless, and RSVP staff recommend placements to volunteers which match their interests and skills.

In 1989, RSVP's twelve-hundred (1200) volunteers contributed 178,000 hours to the health and well-being of the Rochester and Monroe County area. At a very conservative rate of \$8.00 per hour, that represents a contribution of \$1,424,000 worth of services to more than one-hundred (100) non-profit agencies. In addition, RSVP is highly cost-effective; Federal funds supported those volunteers at the rate of only \$.38 per hour.

These figures, however, tell only part of the story about RSVP's effect on the community. As we see it, RSVP has two clients: the non-profit agencies who benefit from the assistance of senior volunteers, and the volunteers themselves who lead healthier and happier lives as a result of their services to others.

Federal funding of RSVP is about \$31 million annually. In addition, each RSVP program is required to raise a minimum of one-third of its budget from non-federal sources. As a result, RSVP programs generate state and local, public and private support nearly equal to the amount of federal funding. Here in Monroe County, 43% of the budget comes from non-federal sources.

Continued Next Page

SUBJECT: SENIOR VOLUNTEERS

Obviously, community support for RSVP is very strong in Monroe County, but it is becoming more and more difficult to raise funds locally and as a project director, I am spending an ever increasing proportion of my time fund raising rather than attending to programmatic issues.

ACTION projects have suffered real hardships over the last decade because ACTION grants have no mechanism to deal with inflation. Congress tried to relieve some of the pressure through a one-time cost of living (COLA) increase for FY88. RSVP received a 3.4% increase after more than a decade without inflationary increases. We feel provisions need to be made, through authorizing legislation, to insure grantees receive a minimal COLA each time the annual grant is renewed.

In addition, RSVP projects are asked every year to increase the number of volunteers in certain "ACTION Emphasis Areas," such as substance abuse and intergenerational programming, but are not provided the necessary funds for program expansion. In reality, we are struggling to current laudable programming, while program expansion remains a laudable, but unattainable goal.

RSVP's mission is to provide senior volunteers to help solve a variety of serious community problems, and if we are expected to fulfill that charge, then adequate funding must be provided. My recommendation is that a one-time, fifty-percent (50%) increase in RSVP funding be made to allow us to cover the losses of the last decade due to a lack of cost-of-living increases and provide a solid foundation for program expansion.

With the assistance of this increase, project directors would be able to concentrate their efforts on recruiting and placing volunteers in the more difficult assignments.

REGIONAL COUNCIL ON AGING, INC. June 11, 1990
Rochester, New York 14604

Lorraine Anderson
Director, RSVP

SUBJECT: EMPLOYING THE OLDER WORKER

The framers of the Older Americans Act were farsighted in their recognition of the need for a range of services to help keep our older citizens independent and productive for as long as possible. Chief among the programs initiated by the Older Americans Act are those mandated under Title V which provide for employment and retraining for those age fifty-five and older. Under the aegis of the Older American Act, Title V Senior Community Service Employment Programs have emerged as successful, innovative models for the employment and training of older Americans.

At the Regional Council on Aging we consider employment assistance to be one of the most important services we offer because it allows a person to maintain higher independence and self-respect. Through our GROW Employment Service, we run programs for Displaced Homemakers, Dislocated Workers, Title V, Job Training Partnership Act (JTPA) and a new emphasis called Productivity Plus.

There are particularly three points about federal employment programs which need to be highlighted.

1. As we face this new decade, it is time to reevaluate the state of our nation's employment and training services for older workers. Several changes are now upon us. For one, the increase in the federal minimum wage has resulted in a decrease in the number of people who will be served by Title V Senior Community Service Employment Programs. This is occurring at a time when our nation is facing the crisis of a declining work force. Clearly, these changes point to a need to allocate additional funds under Title V for the employment and training of our senior work force.
2. Within the Job Training Partnership Act (JTPA), the other piece of federal legislation that targets funds to older worker employment and training, we find a dramatic shift in public policy. The three percent set aside within JTPA, which targets funds for older workers, is about to be eliminated. Without the advocacy of the Older Americans Act there is every indication that older workers will be overlooked once this set aside is eliminated. Therefore, it is imperative that the Older Americans Act call for special targeted employment and training programs for older workers within the Job Training Partnership Act.
3. Many older workers are reluctant to work because they are afraid of losing their Social Security benefits. Social Security serves as a disincentive for workers to reenter or remain in the work force. Even when faced with living in poverty many of our older citizens are

Continued Next Page

SUBJECT: EMPLOYING THE OLDER WORKER

fearful of jeopardizing their Social Security benefits by seeking employment; employment which would provide social, emotional and financial benefits. This is occurring at a time when they are very much needed due to the decline in new entrants into the labor market. This flaw in the Social Security regulations results in a form of age discrimination which limits the employment opportunities of our older citizens. The need for advocacy in this area is clear.

Political and social forces in our society are converging to decrease employment opportunities for older workers. The changes within JTPA and the inadequate changes in Social Security earnings limitations are indicative of a need for policy initiatives under the Older Americans Act which address the concerns of our older workers. These limiting legislative factors are decreasing services and the opportunity for productivity and self-sufficiency through employment for older individuals. Clearly, it is necessary for the Older American Act to serve as a coordinating force for employment and training programs for older Americans and to assume the role of encouraging and assisting federal, state and local agencies to concentrate resources into coordinated service systems. Only by formulating a cohesive employment and training policy for older workers at the federal level under the Older Americans Act will our nation be able to effectively utilize scarce resources and remove barriers to economic and personal independence for older individuals.

REGIONAL COUNCIL ON AGING, INC. June 11, 1990
Rochester, New York 14604

Nyla Gaylord
V.P. Employment
Services, GROW

SUBJECT: IN-HOME SUPPORT SERVICES

The Commonwealth Fund Report, *Aging Alone*, indicates that 25% of all elderly persons living alone have difficulty with one or more daily tasks. Our own door-to-door canvassing in towns around Rochester, N.Y., indicates that at least 35% of persons 75 or older living alone require assistance in securing home support services that will enable them to continue to live independently. Not only is our population as a whole aging, but the 85+ age group, most in need of such services, is the fastest growing segment of our population.

Currently, Title IIIB and IIID authorize home-delivered meals, home health care, homemaker, errand, visitation, and home maintenance services. In Monroe County, it is common for seniors desiring these services to have a waiting period of several months to secure them, due to limited funding and limited availability of paid workers and supervised volunteers. Such services not only enable frail elderly to continue to live at home, rather than in long term care facilities, but they can function as preventative measures to slow the decline in functioning. Home maintenance interventions may prevent falls; balanced and carefully monitored nutrition is essential to good health; and a friendly visitor can alert agencies or long-distance caregivers to a problem before it develops into a crisis.

Our Home Help for Seniors program uses Title IIID funds to purchase and install grab bars, raised toilet seats, and other safety equipment in the home. This has allowed hospitals to discharge patients earlier than they might otherwise, since getting in and out of the bathtub is a most difficult and often dangerous activity for recuperating older patients. It is a far less expensive alternative to home health care as well. We also install smoke detectors, which can forestall tragedy for seniors whose sense of smell has declined with age.

Case management is essential to locating seniors who need such help, assess the need for assistance, and arrange a package of services for them. Without such help, service is delivered not on a basis of need, but on the basis of the skill of an impaired senior to advocate for her/himself.

In this country, our expenditures for the elderly go predominantly for skilled medical care for acute illness. As a society, we ignore the progressive deterioration of our elderly until their problems reach crisis proportions, resulting in far higher costs than might otherwise have been necessary.

We, therefore, recommend the increased allocation of funds to prevention-oriented home support services, along with case management/ outreach programs to oversee them. This should, in time, greatly reduce both Medicare and Medicaid outlays for acute and institutional care, as well as, provide simple, inexpensive and easily administered interventions that enhance the dignity and independence of our most at-risk population.

REGIONAL COUNCIL ON AGING, INC.
Rochester, New York 14604

June 11, 1990 Debra Sponable
Director, Home Help for Srs.

Mr. DOWNEY. The subcommittee will now hear from Sheldon Jaffee, who is the Deputy Director for Federal Relations, New York State Office for the Aging. Mr. Jaffee. You may sit down.

STATEMENT OF SHELDON JAFFEE, DEPUTY DIRECTOR FOR FEDERAL RELATIONS, NEW YORK STATE OFFICE FOR THE AGING

Mr. JAFFEE. Good morning, Chairman Downey, Congresswoman Slaughter. I'm Sheldon Jaffee, the Deputy Director for Federal Relations of the New York State Office for the Aging. I am here to present testimony on behalf of Jane G. Gould, who is the Director of the State Office for the Aging, but was unable herself to be here, but thought it important enough to send one of her staff members.

We appreciate and want to thank you for this opportunity that you provided us and everybody else here to provide testimony on the subject of the Older Americans Act: Health Promotion and Education and Other Unfunded Programs. The State Office for the Aging is very interested in the general issue of funding for Older Americans Act programs and Older Americans Act type programs. When I use the term "Older Americans Act type programs," I refer to programs that are not authorized or created by the Older Americans Act itself, but instead, are programs carried out by New York State and its localities that are keeping with the intent and the spirit of that act. Some of these programs are very familiar to you. They are Community Services for the Elderly, the Supplemental Nutrition Assistance Program for the Frail Elderly, the Expanded In-Home Services Program and the Recreation Program for the Elderly.

We recently sent to the New York State Congressional Delegation figures on New York State and localities spending on Older Americans Act Programs and Older Americans Act type programs over the past few Federal fiscal years. Allow me to repeat briefly some of those figures here.

In the past 4 years, State and local governments of New York have significantly increased their financial commitment to programs for the elderly. During that same period, the financial commitment at the Federal level has remained virtually unchanged.

In Federal fiscal year 1986, New York State and local governments spent over \$22 million in Older American Title III programs. We spent an additional \$20 million on the State and local programs I mentioned earlier, such as the community services for the elderly, all of which are keeping in the spirit of the Older Americans Act, and in truth, without the Older Americans Act, would probably not have been in existence. By Federal fiscal year 1989, State and local spending increased by more than 51 percent to nearly \$65 million.

In the same 4 years, Federal funding went from \$46.1 million to \$49.5 million. This represents an increase of only \$3.4 million, less than 7.5 percent, when the States and the localities increased spending by five times as much.

Of the 100—the figures cited here are for New York alone. Other States may well have a similar story to tell you. Now, New York and other States, especially in the Northeast, face tough times as our economic growth slows down. Someone else has to help make

up the erosion of inflation, the growing demand for services and the current unmet need for services.

While I have digressed a bit from the subject of this hearing, I think the figures cited highlight the enormity and the importance of the task facing not only those of us in the aging network, but you and your colleagues in Congress as well.

Many of the programs at present authorized and funded by the Federal Government under the Older Americans Act are not keeping pace with the need, even when supplemented by State programs and local funds. Yet, many of the programs presented authorized, but unfunded, are also needed.

Can we fund authorized, but unfunded, programs while increasing funding for programs that are currently underfunded? This question may sound like a conundrum, but is a conundrum that we will soon have to resolve. This hearing that you have called, of course, is an early step towards such a solution.

Specifically, I would like to talk about Part F of the act, Preventive Health Services. I start with this part, not only because health promotion and education is a primary topic of this hearing, but because of a strong belief that preventive health services should be funded. Many of the programs under Parts B and C of the Older Americans Act are inherently preventive in nature. A program aimed at preventing premature deterioration of the physical condition of the elderly is in keeping with the spirit of the act, that of maintaining the dignity of the individual in a democratic society and continuing in their own community as long as possible.

There never has been a categorical set-aside for primary preventive programming. Yet, it is generally agreed that the best approach to the prevention of a negative aging process is that knowledge and availability of preventive and promotion activities. These activities include, but are not limited to, routine health screening and services counseling.

During the past decade, the Administration on Aging, in conjunction with the Public Health Service, tried to stimulate a national health promotion program. The absence of substantial resources hampered their efforts. Funding a program of preventive services would provide a new, needed and publicly popular program for the network.

The Long-Term Care Ombudsman Program is a key part of the quality assurance system for residents of long-term care facilities. Section 307(a) of the act sets out in great detail the assurances the State plans must meet in regard to this program. The detail is greater than that required for nutrition services or legal assistance. Yet, for all practical purposes, the Long-Term Care Ombudsman Program remains virtually an unfunded program.

Leaving aside the desirability, in humanistic terms, of maintaining and adequately funding this program, government has a tremendous financial stake in quality care in long-term care residence facilities. Medicaid accounts for approximately \$3 billion in annual costs in the nursing home industry in New York State alone. This is over \$8 million a day. The Long-Term Care Ombudsman Program plays a key role by working with the nursing home industry and its regulators to identify and correct quality of care and compliance problems.

The ability of the program to receive, investigate and resolve complaints is essential to its success. Yet, there are widespread gaps in the complaint resolution service of this program due to lack of adequate Federal funding. We cannot allow our most vulnerable elderly to go unprotected. A separate title within the Older Americans Act, plus an infusion of financial resources, will bring a new vitality to the program. Therefore, we strongly recommend the Long-Term Care Ombudsman Program be given a separate title within the Older Americans Act, plus a separate funding authorization and allocation without a trigger provision.

The next portion that we would like to talk about is the prevention of abuse, neglect and exploitation of older Americans. It is an understatement to say there has been a heightening of the public's awareness of the various types of abuse that are present in our society. Child abuse and spousal abuse, particularly wife beating, have been the topics of several television and theatrical movies. In real life, the rate of elder abuse by families and in institutional settings is increasing throughout the country.

To witness, either in movies or in real life, the abuse of one human being by another is to witness a descent into the darkest aspects of that which we call humanity. Make no mistake about it. Abuse in any form is horrible, demeaning, frightening and threatening. It is the very antithesis of the inherent dignity of the individual that the Older Americans Act seeks to assure for our Nation's elderly.

Elder abuse is a problem in our society, and like any form of abuse, it must be addressed. To tolerate it would be, in my opinion, irrefutable proof that we do not aspire to be a kinder and gentler Nation.

The aging network as a whole has a large stake in confronting this problem of elder abuse. Therefore, I urge you to authorize and appropriate funding for a program to address the problem of elder abuse. This program should include resource centers, hot lines and an elder abuse reporting system. Placed within the aging network, it would coordinate its work with the Legal Assistance and Long-Term Care Ombudsman Programs. It should supplement, but not usurp the efforts of the Protective Service for Adults Programs.

In closing, the 1980's saw the States thrust into the position of taking greater and greater responsibility for social programs, such as those authorized under the Older Americans Act. I think it can be said that we did it in New York because we would not neglect the needs of the elderly, in spite of the fact that the Federal Government bears the major responsibility for meeting those needs.

To repeat a report made earlier, however, many States are now facing tough economic times. The services provided under the Older Americans Act are much needed and much in demand. Likewise, those Older Americans Act type programs provided by the States and its localities are much needed and much in demand. The need and the demand do not go away when times are tough economically. New York, under the leadership of Governor Cuomo, has carried its share and more of the economic burden for financing Older Americans Act and similar programs. Quite simply, we now need the Federal Government to bear more of the economic burden.

It is tempting to think in terms of a "peace dividend" when following the still dramatic events taking place in Eastern Europe. We realize, of course, that the peace dividend is not going to come easily, and it is certainly not going to be an endless well. Yet, cannot we now take time to look towards the needs of those in our own country? Cannot we now take the time to show greater compassion for those who are in need of our assistance?

In his 1984 Message to the State Legislature, Governor Cuomo quoted John F. Kennedy in saying, "Civility is not a sign of weakness and sincerity is always subject to proof." I submit to you that compassion also is not a sign of weakness, and our sincerity is demonstrated by what we as a Nation are willing to devote of our resources to those in need. Thank you.

[The prepared statement of Ms. Gould follows:]

NEW YORK STATE OFFICE FOR THE AGING

Mario M. Cuomo, Governor

2 Empire State Plaza, Albany, NY 12223-0001

Jane G. Gould, Director



TO:

The House Select Committee on Aging
Subcommittee on Human Services

FROM:

Jane G. Gould, Director *JG*
New York State Office for the Aging

DATE:

June 6, 1990

SUBJECT:

Older Americans Act: Health Promotion
and Education and Other Unfunded Programs

UNFUNDED OLDER AMERICANS ACT PROGRAMS

I would like to begin by thanking you for this opportunity to provide testimony on the subject of "Older Americans Act: Health Promotion and Education and Other Unfunded Programs." The New York State Office for the Aging is very interested in the general issue of funding for Older Americans Act Programs and Older Americans Act-type programs. When I use the term "Older Americans Act-type programs," I refer to programs that are not authorized or created by the Older Americans Act, but instead are programs carried out by New York State that are in keeping with the spirit of that Act.

I recently sent to the New York Congressional Delegation figures on New York State spending on Older Americans Act Programs and Older Americans Act type programs over the past few Federal Fiscal Years. Allow me to repeat those figures here.

An Equal Opportunity Employer

1-800-342-9871 Senior Citizens' Hot Line Call toll-free for information about local programs and services

STATE v. FEDERAL FUNDING EFFORTS

A) New York's Efforts

From Federal Fiscal Year 1986 through Federal Fiscal Year 1989, state and local governments in New York have significantly increased their financial commitment to programs for the elderly. During that same period, the financial commitment at the Federal level has remained virtually unchanged.

In Federal Fiscal Year 1986, New York's State and local governments spent over \$22.5 million on Older Americans Act, Title III programs. We spent an additional \$20.4 million on programs such as Community Services for the Elderly, the Supplemental Nutrition Assistance Program for the Frail Elderly, and the Expanded In-home Services for the Elderly Program, all of which are in keeping with the spirit of the Older Americans Act. By Federal Fiscal Year 1989, state and local spending increased by more than 51% to nearly \$65 million.

Federal funding for Older Americans Act, Title III, programs during the same period went from \$46.1 million (FFY 1986) to \$49.5 million (FFY 1989). This represents an increase of only \$3.4 million, less than 7.5 per cent. Of the \$114.5 million spent on programs for the elderly in New York in Federal Fiscal Year 1989, nearly 57% was paid for with state and local dollars.

The figures cited here are for New York alone. Other states may very well have a similar story to tell. Now, New York and other states face tough times as our economic growth slows down.

In the past year alone, inflation has eroded the value of the aging services dollar by 4.7% nationally, and an even higher 5.0% in New York. This means funding for programs for the elderly will have to be increased to meet rising delivery costs if we are to maintain at least last year's service levels.

Yet, even if last year's service levels are maintained, we still will not meet the need. Service levels must grow just to stay even with the rising need and demand. High priority at-risk target groups - the poor, the frail, the isolated and the minority elderly - are growing at an estimated rate of 6.0% each year in New York state alone.

Thus, to simply maintain the current level of aging services in New York, the state must increase delivery from 35.9 million units of service in Federal Fiscal Year 1989, to 38.1 million units of service this year - an increase of 2.2 million units of service - simply to keep pace with demographic changes and just keeping pace is unacceptable.

B) National Association of Area Agencies on Aging Testimony

New Yorkers are not the only ones who find themselves hard pressed to meet the increasing demand for services for their elderly. James McConnell, a member of the board of the National Association of Area Agencies on Aging (NAAAA), recently noted in testimony provided to the House Appropriations Subcommittee on Labor, Health and Human Services that Federal funding for Title III-B programs has increased by only 9% over the last ten years. What is more, according to Mr. McConnell, for Federal Fiscal Year

1990, Title III-B programs are receiving only 65% of their authorization levels. The lower level is due to the Gramm-Rudman-Hollings sequester in the fall of 1989.

The NAAAA claims it will take \$142 million above the current Title III-B appropriation for the Federal government to regain the ground lost since Federal Fiscal Year 1980.

I have digressed a bit from the subject of this hearing. Yet, I think figures cited highlight the enormity and the importance of the task facing not only those of us in the aging network, but you and your colleagues in Congress as well. Many of the programs presently authorized and funded by the Federal government under the Older Americans Act are not keeping pace with the need, even when supplemented by state programs and funds. Yet, many of the programs presently authorized but unfunded are also needed.

Can we fund authorized but unfunded programs while increasing funding for programs that are presently under funded? The question may sound like a riddle, but it is a riddle that we will soon have to solve. This hearing is, of course, an early step toward a solution.

COMMENTS ON SPECIFIC PROGRAMS

A) Part F: Preventive Health Services

I start with this part not only because Health Promotion and Education is a primary topic of this hearing, but because of a strong belief that preventive health services should be funded. Many of the programs under Parts B and C of the Older Americans

Act are inherently preventive in nature. . A program aimed at preventing premature deterioration of the physical condition of the elderly is in keeping with the spirit of the Act, that of maintaining the dignity of the individual in a democratic society.

There has never been a categorical set-aside for primary preventive programming. Yet it is generally agreed that the best approach to the prevention of a negative aging process is the knowledge and availability of preventive and promotion activities. These activities include, but are not limited to, routine health screening, group exercise and wellness programs, drug and medication education, and health services counselling.

During the past decade, the Administration on Aging, in conjunction with the Public Health Service, tried to stimulate a national health promotion program. The absence of substantial resources hampered their efforts. Funding a program of preventive services would provide a new and publicly popular program for the network.

B) The Long Term Care Ombudsman Program

The Long Term Care Ombudsman Program is a key part of the quality assurance system for residents of long term care facilities. Section 307(a) of the Older Americans Act sets out in great detail the assurances the State Plans must meet in

regard to this program. The detail is greater than that required for nutrition services or legal assistance. Yet for all practical purposes, the Long Term Care Ombudsman Program remains virtually an unfunded program.

Leaving aside the desirability, in humanistic terms, of maintaining and adequately funding this program, government has a tremendous financial stake in quality care in long term care residence facilities. Medicaid accounts for approximately \$3 billion in annual costs in the nursing home industry in New York alone. This is over \$8 million a day. The Long Term Care Ombudsman Program plays a key role by working with the nursing home industry and its regulators to identify and correct quality of care and compliance problems.

The ability of the Long Term Care Ombudsman Program to receive, investigate and resolve complaints is essential to its success. Yet there are widespread gaps in the complaint resolution service of this program due to the lack of adequate Federal funding. We cannot allow our most vulnerable elderly to go unprotected. A separate title within the Older Americans Act, plus an infusion of financial resources, will bring a new vitality to the Program. Therefore, I strongly recommend the Long Term Care Ombudsman Program be given a separate title within the Older Americans Act, plus a separate funding authorization and allocation without a trigger provision.

C) Part G: Prevention of Abuse, Neglect,
and Exploitation of Older Individuals

It is an understatement to say that there has been a heightening of the public's awareness of the various types of abuse that are present in our society. Child abuse and spousal abuse, particularly wife-beating, have been the topics of several television and theatrical movies. In real life, the rate of elder abuse by families and in institutional settings is increasing throughout our country.

To witness, either in movies or in real life, the abuse of one human being by another is to witness a descent into the darkest aspects of that which we call humanity. Make no mistake about it; abuse in any form is horrible, demeaning, frightening, and threatening. It is the very antithesis of the inherent dignity of the individual that the Older Americans Act seeks to assure for our nation's elderly.

Elder abuse is a problem in our society and like any form of abuse, it must be addressed. To tolerate it would be, in my opinion, irrefutable proof that we do not aspire to be a kinder and gentler nation.

Elder abuse in this country is largely addressed through the Protective Service for Adults Program. I would not minimize their efforts. Yet, abuse must be addressed on several fronts. The Long Term Care Ombudsman Program can play a role in this area, as can the Legal Assistance Program. The Aging Network, as a whole, has a large stake in confronting the problem. Therefore, I urge you to authorize and appropriate funding for a

program to address the problem of elder abuse. This program should include resource centers, hot lines, and an elder abuse reporting system. Placed within the Aging Network, it would coordinate its work with the Legal Assistance and Long Term Care Ombudsman Programs. It should supplement, but not usurp, the efforts of the Protective Services for Adults Program.

I urge you, in the strongest of terms, to address the problem of elder abuse. It is a plague on our society and must not be tolerated.

D) Part E: Additional Assistance for Special Needs of Older Individuals

I would urge that this part be eliminated only if funding for Title III-B programs is increased to meet their ongoing needs, plus the special needs these programs were intended to meet. Otherwise, I suggest they be left as is: authorized but subject to an appropriations trigger.

E) Part D: In-Home Services

This is not an unfunded program, but it most certainly is a grossly under funded program. In fact, given the minuscule current appropriations, the program is all but non-existent. Clearly, greater strides must be made in this area. The need is there, as demonstrated by New York's own Expanded In-Home Services for the Elderly Program (EISEP). Yet, to repeat the point, the resources presently devoted in this area are embarrassingly inadequate.

GENERAL COMMENTS

Before making a closing statement, I would like to make a few observations that are not keyed to specific programs, but to the Older Americans Act and funding of its programs generally.

A) The Appropriations Trigger

Appropriations triggers serve to guard against disruptions of existing programs. However, current service levels should not always be fully funded before appropriations are made for new programs. Some new programs, such as those targeted at care givers and families of those with Alzheimer disease, may warrant exceptions.

B) Cost-Sharing

Cost-sharing may be viewed by some as an additional source of revenue to fund previously unfunded or under funded programs. To take this view would be a mistake. Cost-sharing may play a role in future Older Americans Act Programs, but only to help to expand available resources. First, however, other funding possibilities must be examined. Furthermore, clear guidelines on what programs and services would be allowed to use cost-sharing mechanisms must be developed.

C) Title IV: Training, Research and Discretionary Projects and Programs

While obviously outside the domain of Title III, there are a number of training, research and discretionary projects and programs that are unfunded or under funded pursuant to Title IV of the Older Americans Act. While these projects and programs are important, present funding efforts severely limit their

efficacy. I suggest that the Administration on Aging and the States be given some discretion over the use of funds that otherwise are available for Title IV in an effort to target resources to the most timely and current research and development needs.

CLOSING REMARKS

The 1980's saw the states thrust into the position of taking greater and greater responsibility for social programs, such as those authorized under the Older Americans Act. I think it can be said that we did it in New York because we would not neglect the needs of the elderly in spite of the fact that the Federal Government bears a major responsibility for meeting those needs.

To repeat a point made earlier, however, many states are now facing tough economic times. The services provided under the Older Americans Act are much needed and much in demand. Likewise, those Older Americans Act-type programs provided by the states are much needed and much in demand. The need and the demand do not go away when times are tough economically. New York, under the leadership of Governor Cuomo, has carried its share and more of the economic burden for financing Older Americans Act and similar programs. Quite simply, we now need the Federal government to bear more of the economic burden.

It is tempting to think in terms of a "peace dividend" when following the still dramatic events taking place in Eastern Europe. We realize, of course, that the peace dividend is not going to be an endless well. Yet can't we now take time to look

inward to the needs of those in our own country? Can't we now take the time to show greater compassion for those who are in need of our assistance?

In his 1984 Message to the New York State Legislature, Governor Mario Cuomo quoted John F. Kennedy in saying: "Civility is not a sign of weakness and sincerity is always subject to proof." I submit to you that compassion also is not a sign of weakness and our sincerity is demonstrated by what we as, a nation, are willing to devote of our resources to those in need.

Thank you.

Mr. DOWNEY. Thank you, Mr. Jaffee. Let me ask you briefly. You mentioned the Ombudsman Program not being subject to the appropriation trigger, and you also—I think some place else in your statement—suggest that the programs targeted at Alzheimer's disease not be subject to the trigger as well?

Mr. JAFFEE. Right.

Mr. DOWNEY. What criteria would you use for determining what should be—I mean, I personally feel that none of them should be subject to the trigger. I mean, let us start from there. But, assuming some of them are and some of them are not, what criteria would you use?

Mr. JAFFEE. Well, starting from one side—we do not want to see current service programs disrupted.

Mr. DOWNEY. Right.

Mr. JAFFEE. But yet, more and more knowledge comes and more and more times change, Congress, as a policy setter, as well as a funder, has to make judgments about what programs have to break this kind of thing. While keeping the whole whole, what else has to be done? In our judgment, the issues that we see in elder abuse, the long-term care, ombudsman program and Alzheimer's diseases are sufficiently strong that we put it to you for your consideration.

Mr. DOWNEY. In Washington, we had a hearing about some of the more interesting aspects—the public/private partnerships that are going on across the country between the existing area Offices of Aging and some corporate involvement. And one of the persons who testified suggested that if the State Office for Aging were able to provide local agencies with technical assistance to help them to develop private sources of support, that that would be very helpful. Do you know of any technical services that our State provides to local area agencies that do that sort of thing?

Mr. JAFFEE. Most—not in a sense directly targeted to elder care, as they are now starting to call it—it is now starting to be called. Obviously, we provide a lot of technical assistance. This whole thing of this public/private partnership is new and troubling to many people in the network. There is a major concern that the targeting aspects and that those who are providing services most in need—economic need and social need—not be deprived as we march to a different drum. But obviously, we cannot stick our head in the sand as time moves on and corporations are willing to realize that they have a sandwich generation and that their employees are either themselves caring for elderly people or becoming elderly and, therefore, in the need of services.

We are now serving, in fact, we asked our area agencies, and we are supposed to hear from them back in June as to what they see the directions we will be going on, and then in consultation with them, we will be setting policy. But, there are many things that we do now and area agencies do now that are in there. There is no such thing as respite service. It is like a bundle of different services tailored to whatever a particular person needs. It is a very troubling thing, and I am sure that even within this room, if there are 100 people here, there are probably 250 different opinions of it.

Mr. DOWNEY. Yes. I am going to send you the testimony because I was less troubled by it after I heard that a number of these public/private partnerships augment services and, in fact, from the

people that we heard that some services would not have been able to have been offered to anybody without this involvement. But personally, I would prefer that we have a lot more money for the Older Americans Act, then we would have to have less of this. But, it seems to me that there are some innovative and creative things that have happened out there, and we will make you privy to this testimony.

Mr. JAFFEE. We appreciate that very much.

Mr. DOWNEY. Thank you very much.

Mr. JAFFEE. We, in turn, will share it with the rest of the network.

Mr. DOWNEY. Terrific.

Mr. JAFFEE. Thank you.

Mr. DOWNEY. Louise.

Ms. SLAUGHTER. Mr. Jaffee, I would like to follow up a little bit on the part about the preventive health services because that is the piece that I wrote. Obviously, what we had in mind was that screening at Senior Centers would help to find cases of glaucoma, diabetes, maybe heart disease, high blood pressure, and other things that we felt that maybe seniors would not go to the doctor early enough to diagnose and effectively treat. Our intent was to try to save them from misery and pain, but obviously, at the same time, we understood that if you detect these conditions earlier, treatment is easier and less expensive. Would it be possible at all for you to give us any figures on what the State might have spent on medical care that we might have saved had this health screening been funded?

Mr. JAFFEE. I would have to provide it to you—but, I know that, for instance, nursing home care, as I said, is over \$3 billion a year in New York State, and 95 percent of that is for the care of the elderly. And too often, nursing home is a resort that is gone to too early and too soon because community-base care can keep people comfortably in their community as long as possible.

I am not aware of any studies that are directly coming to the kinds of figures that we are doing in the Supplemental Nutrition Assistance Program for the frail elderly, a surveillance effort in connection with Cornell University. And, we have gotten some preliminary reports where just the thing of ensuring that people eat, they are starting to see ties in with reducing acute care episodes. I think intuitively, everybody would agree that prevention is the cheapest and best way of doing it. Of course, sometimes, you know, as we all get older and everything like that, you need more intensive care and things like that. And many of these services are being provided under Title III(b).

Ms. SLAUGHTER. Also, I wanted to speak on the elder abuse, which is tragic in the extreme because so many elderly people do not feel that they can go for the help that they need.

Mr. JAFFEE. Right.

Ms. SLAUGHTER. The elderly often feel that they would be alone and totally uncared for, and that is a tragedy. I think one of the things that we have to really concentrate on are the elderly who are alone.

Mr. JAFFEE. Right.

Ms. SLAUGHTER. The elderly who face all these problems by themselves. Without the State and the Regional Councils on Aging, these seniors would have no place else to turn. It would be helpful to me if you have any data which indicates that the State of New York spent money they might have saved had there been this kind of resource at the Regional Councils. This data would help us underscore the need for Federal funding of these services.

Mr. JAFFEE. Okay. We will find that and send you any information if we have it.

Ms. SLAUGHTER. Thank you.

Mr. JAFFEE. Thank you.

Mr. DOWNEY. Thank you, Mr. Jaffee.

Ms. Williams, we know you have just gotten here. We would like to receive your testimony if you are ready to go. Margaret Williams is the President of the National Association of Area Agencies on Aging.

Ms. SLAUGHTER. Margaret, do you want some water? You just walked in the door.

Mr. DOWNEY. She just walked in the door from a long trip. Please proceed.

STATEMENT OF MARGARET WILLIAMS, PRESIDENT, NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING

Ms. WILLIAMS. Thank you. Good morning. I am very happy to be here today in the beautiful city of Rochester on behalf of the National Association of Area Agencies on Aging. We have handed in testimony which basically answers the questions that were raised as to what this hearing was being held for. And I would like to just speak briefly about that and then also look into two other issues.

One of the main problems with the Older Americans Act is that it has not been funded to the level of the need. I do not know how many of you represent Area Agencies on Aging, but if you agree with that, would you raise your hand. I think all of us—the Federal Government, the State Government and local Area Agencies on Aging should be very proud of what they have accomplished with really a minimum amount of funding. You may not be aware of this, but since 1980, the Older Americans Act has only received a 9 percent increase. Now, I do not know if you know what the rate of inflation has been, what the increase in our services have been, or the number of older people that we now serve. But, 9 percent really has put us well below what we could have done in 1980.

So, I would ask the subcommittee first of all to look at the funding, especially for III(b). We want to do a good job, and I think we have done an excellent job. But, if we had more dollars to use judiciously, cost effectively and efficiently—all of those good words—we certainly would be able to serve older people who need help. It gets very discouraging for all of us to know the need, and yet, not to be able to provide those services, specifically in-home services.

I also talk about several other issues in my printed testimony, including the fact that all of the added programs that was put in the last reauthorization really have not been triggered, so we have not been able to do those things, even though Congress felt they

were extremely important for us to accomplish. We cannot do those things until we get the adequate money into III(b).

One of the other issues that Congress has raised is, what is the need? Where is the real need? And we have not really been able to document that in a way that will justify more and more dollars. So, I would also ask that Congress look at a national data base. We did have this a number of years ago with NASUA, the National Association of State Units on Aging, and the National Association of Area Agencies on Aging. I would like to see that reinstated, and I would like to see that funded so that we can—when you ask, how many people need this—what is the need here—that we can give you accurate information.

Beyond those two issues, we need more money and we need a better way to gain information. There are a couple of other issues that were really not raised in the request for testimony that I would like to talk about. I have been talking to Congresswoman Slaughter and her office staff about these two issues.

The first one is Title V. Title V provides funds for older, low-income workers to provide services to the community. Madison County Office for the Aging, which is the agency I represent, has used Title V workers since the very beginning. They are a tremendous asset to us and the community. They do all kinds of things—everything from working in school systems to working in Senior Centers to working in elder abuse offices—any type of community service. We have them in our daycare programs, our nutrition programs. They do outreach. They are dynamite, and they do a great job. We are having trouble finding people to fill those job slots. And, I think there are two issues that if Congress addressed, would help us provide work—meaningful work—to older people who would like to work, but because of these two issues, are not able to take those jobs.

One of them is that it is 125 percent of the poverty level, which is—you have to have income below that amount, which is extremely low, especially in New York State and in rural areas. If you have an income that low, you do not have transportation. You have other things that are going on in your life that really prevent you from coming to work, even though you would like to and even though you could do a good job and contribute. I would suggest that we look at the poverty level of 125 percent and raise that so that we can get some more people into the program.

The second issue with Title V is the fact that these people are allowed to work 1,300 hours a year, which is part-time, and therefore, most of them are not eligible for health insurance under the sponsoring agency that they work for. Plus the fact, there is not enough money in the amount of money that comes through Title V to pick up those health care costs.

So, you have people who have chronic illnesses, who have some illnesses that require constant medical care, and if they come onto Title V, they lose their Medicaid. Very often, we have to counsel older people to be sure that they understand what they will be giving up in order to come to work. That is very difficult if you have someone who has multiple chronic ailments who really needs constant care, but who could really work, and say to them, "Well, you are going to lose your medical insurance because you are no

longer going to be eligible for Medicaid because of the income you will be getting from this job."

Now, a few years ago, we did have an amendment that Congresswoman Slaughter introduced which eliminated the income as to be counted for food stamps and subsidized apartments. That was a big help, and I certainly would like us to look at Medicaid to see if there is not some way that we can eliminate this income as countable income for Medicaid programs. One of the problems with this is we do not have any statistics. We really cannot tell you what kind of an impact this would have. Maybe it would be simpler to fund Title V enough to pay for medical insurance through the sponsoring agency. I am not sure, but we need to look at medical insurance. That is very important.

The second issue that I wanted to talk about was medical insurance for all older people. You know, there are lots of barriers to services, and one of the biggest ones we have is a paper barrier. How do you get through the paper to get your medical insurance payments? I have heard that as high as 30 percent of Medicare dollars are not claimed because of the paperwork. Misunderstanding—"What do I get?", "How do I get it?"—and the other issue with it is, what Medigap insurance should I get to go with my Medicare?

In the late 1970's when our office opened, one of the first things we discovered was that people were carrying multiple policies that would not pay for anything that was not Medicare eligible. They read that line in the policy to mean, "If I am Medicare eligible, then this policy will fall into place," but it was not. If the claim was not Medicare eligible, all this extra insurance was not worth anything. We found people on Medicaid who were carrying Medigap insurance. We found people who were carrying multiple policies that would not pay if the other one paid.

So, one of the first things we did was to work with the insurance underwriters in Utica. We set up all day training. We dedicated 50 percent of one of our Title III(b) workers to work with people to help them through the insurance maze. We have had a very good program all of these years, but I do not see the need diminishing at all, even though we have had public education. We have people who bring shoeboxes in with forms. We had a man who was on our Board who was a treasurer of a school system who was a mayor of a city when he got sick and went in the hospital at the age of 75. He could not figure it out.

So, this has nothing to do with intelligence. It has nothing to do with understanding of money. It is a complex system that we need to look at. I would suggest that somewhere—even though as I have said, no new mandates without more dollars—that we need to look at helping people with medical insurance, and I would suggest that the Offices for the Aging and their subcontractors are the appropriate place to do this—where people go for certain services. This is one of the main problems that older people have.

With that, basically, I would like to thank you and would be happy to answer any questions for you.

[The prepared statement of Ms. Williams follows:]

TESTIMONY OF

THE NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING

Offered by

Margaret Williams
President

before the

UNITED STATES HOUSE OF REPRESENTATIVES

SELECT COMMITTEE ON AGING

Field Hearing, Rochester, N.Y.

on the subject of

UNFUNDED PROGRAMS UNDER TITLE III OF THE OLDER AMERICANS ACT

June, 1990

The Honorable Thomas J. Downey, Chairman

Mr. Chairman and members of the Subcommittee on Human Services, I am Margaret Williams, Vice President - Administrator of Bethany Retirement Center, and President of the National Association of Area Agencies on Aging. I am pleased to have the opportunity to present testimony at this oversight hearing on the Older Americans Act. We commend you for holding this hearing; it is important that we periodically review and update the Older Americans Act to assure that it adequately addresses the needs of the older persons.

Bethany Center is a not for profit long term residential and health care complex made up of 3 corporations. Services are provided to retired individuals as well as those in need of skilled nursing care without regard to sex, race, religion or national origin.

In addition to the Homes, Subsidized Apartments, Retirement Home, and Nursing Home, Bethany maintains the ABC Nursery School, 4 C's Child Daycare and the off campus multiple service agency - Madison County Office for the Aging - an area agency on aging.

The National Association of Area agencies on Aging

The National Association of Area Agencies on Aging (NAAAA) is the national organization representing the network of over 670 Area Agencies on Aging across the nation. Area Agencies on Aging were established, as a result of the 1973 amendments to the Older Americans Act, to address the needs of older Americans aged 60 and over within each local community. The Area Agency on Aging is the vital link between the local community and many of the Federal and State programs available to older persons. Area Agencies on Aging are charged with assuring the availability of a comprehensive array of services for the elderly, and they are responsible for developing and coordinating locally-based social and nutritional services which help older persons remain independent in their own homes and communities. The primary mission of Area Agencies on Aging is to: (a) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self care with appropriate support services;

National Assoc. of Area Agencies on Aging (continued)
Page 2

(b) remove individual and social barriers to economic and personal independence for older persons; and (c) provide a continuum of community -based and in-home care for the vulnerable elderly, thereby avoiding premature or inappropriate institutionalization.

In my testimony this morning I want to first address the Older Americans Act, giving emphasis to provisions pertaining to health and health education for older persons, and then discuss the need for improved information from the aging network.

Older Americans Act Amendments of 1987

The 1987 amendments made several important changes to the Older Americans Act, including (a) outreach services for older persons eligible for supplemental security income, food stamps, and medicaid programs; (b) a renewed emphasis on minority elderly and those with greatest economic and social need; (c) a separate authorization for the Long-Term Care Ombudsman program; and (d) separate subtitles for frail elderly, elder abuse prevention, elderly with special needs, and preventive health services. The thrust of these amendments was to increase service delivery to older persons and to provide vulnerable elderly with mechanisms for personal protection.

With the addition of these new amendments to existing programs, the Older Americans Act can be viewed as health legislation, as many of the programs funded under the umbrella of Title III address the health and psychosocial needs of older persons. Included under the Act are provisions for health care, health maintenance and screenings, and prevention programs. For example, included under Title III are home health care, nutritional counseling, in-home and congregate meals, health education programs, smoking cessation programs, exercise programs, and transportation for doctor visits.

Older Americans Act (continued)

Page 3

In addition, the outreach provision to assist older persons obtain benefits to which they are entitled, often serve to aide the individual in paying for health care and medication, or in improving their level of nutrition. The elder abuse prevention and ombudsman programs have direct implications for the health and well-being of the elderly. One of the strongest features of the Older Americans Act is that these services and benefits are available to all persons age 60 and older.

Unfortunately, funding for the Older Americans Act has not kept pace with inflation, increased demand, or the increase in the number of older persons in our society. For example, the appropriation level for Title III-B, Supportive Services and Senior Centers, increased by only 9 percent between FY 80 and FY 90. As a result, the elder abuse protection, health promotion, and special needs amendments have not reached the funding level trigger that likewise, has not appropriated funds. Overall, funding support for the Older Americans Act has declined. The ratio of appropriation levels to authorization levels has decreased since 1985, to where Title III-B received only 65 percent of its authorization level in FY 90. The Long-Term Care Ombudsman program received only 5 percent of its authorized funding. This level of support is not adequate enough to allow the broad goals and objectives of the Older Americans Act to be met. Older persons in need of Older Americans Act services are not receiving them.

What is happening at the national level is also true for New York. We are similar to the rest of the country in that our older population is growing, especially the old, old. These are the people who need an increasing number of in-home services to help them remain in their own homes. An adequate supply of services such as personal care, chore services, home delivered meals, counseling, housing repair and remodeling, information and assistance in applying for

New York State (continued)

Page 4

services for which they are eligible, and transportation are sorely needed. We have waiting lists for in-home services with no means to supply these services. New York State instituted the Expanded-in-Home services for the Elderly Program (EISEP) and has tried to help with this problem, but New York like many states has fiscal problems and has not been able to increase the funding needed to meet the need.

To address these concerns, I recommend that Congress pass provisions to:

- * increase the authorization level of all Older Americans Act programs, with particular emphasis on Title III-B, Supportive Services and Senior Centers;

- * require that any new responsibilities or special mandates introduced into Title III programs must be accompanied by additional funding. Additional service requirements have often been added to the Act without a concurrent increase in funding to meet the new responsibilities. To add new responsibilities without a funding increase dilutes existing programs.

National Data Base on Aging

I also recommend that program reporting requirements for the Older Americans Act be revised and streamlined and the National Data Base on Aging be reactivated and included within the Act. Currently, while an over-abundance of information is being collected, little of it is useful in determining unmet service needs. Information on service utilization, activities and the kinds of services provided, and the level of unmet need is crucial for planning within the aging network, and for congressional budget, appropriations, and oversight processes.

Conclusion

Page 5

Mr. Chairman, I thank you for this opportunity to present my views on the Older Americans Act. The Bethany Center and National Association of Area Agencies on Aging strongly supports your efforts on behalf of older Americans.

Mr. DOWNEY. Ms. Williams, you have been very helpful. And do not think that we were not paying attention when we were chatting. We were just talking about something that you said. We are faced with a somewhat interesting and problematic dilemma in Congress. There is a major effort underway to change the Social Security earnings test to allow more earnings for people, which is fine, except that it is enormously costly and it goes to everyone. And it will cost us \$2 or \$3 billion a year. If we were to apply this money to Title V—if we were to increase what is approximately, what, about \$400 million a year nationwide program to \$2 billion or \$3 billion, would you suggest that we could have a significant impact on people who worked under this program—be able to increase the number, be able to provide the changes in the earnings test that you suggest, as well as the number of hours that they would be eligible for health insurance or be able to maintain their health insurance?

Ms. WILLIAMS. That is really a hard question because I have not seen the other proposal and the magnitude. I can only speak to Title V as having a major problem with older people who would like to work, and part-time is an excellent opportunity for them.

Mr. DOWNEY. Yes.

Ms. WILLIAMS. I have not heard of your other proposal and who it would impact and how it would impact people.

Mr. DOWNEY. Sure. But just from your perspective on Title V, it would have a significant impact if we were to provide a lot more money, and you think there are people out there to—

Ms. WILLIAMS. If you raise the income criteria and somehow assisted with the medical insurance. Now, as I said, I have not heard your other—

Mr. DOWNEY. Well, the other is simply taking whatever the earnings test now—a 92 or 9,400 up to 12,000, I think—13,000.

Ms. WILLIAMS. Well, if you want to get into Social Security, I have a very large problem that unearned income does not count and earned income does because very often, the person who has earned income needs it. And I am not saying that we should take away from people who have the unearned income, but I do think there is a discrepancy there, and I know what the original thought was of retirement.

Mr. DOWNEY. Right.

Ms. WILLIAMS. But, we have a different set of circumstances and a different culture today.

Mr. DOWNEY. Yes, I would like to increase the earnings test, too. But, if I were going to spend limited resources, I would prefer to target this money to the people who really need it. I am not suggesting that the people who go from 9 to 12 do not really need it. But, I think in terms of the impact on the poor elderly, that this would give us a double bang for the buck to be able to provide them more money and, in turn, get greater services from the elderly in areas where we need it—other home help programs and foster grandparents—a whole variety of things.

I will send you this change so that you can evaluate this.

Ms. WILLIAMS. Okay. I would appreciate that because I do think that is kind of a new twist that we have not heard that much about.

Mr. DOWNEY. No, well, you will start to hear about it, I am sure, since there are—

Ms. WILLIAMS. I would hope you would not have to make a choice. That you could do both.

Mr. DOWNEY. Well, we will not be able to do both. We are going to be able to do one or the other, and I would like to have your judgment as to which you would prefer to see us do.

Ms. WILLIAMS. If I could look at that, I would—

Mr. DOWNEY. I am not even sure that we would have this choice, but—Louise.

Ms. SLAUGHTER. Margaret, you really gave a statistic that stuns me, and that was the one that 30 percent of benefits were not claimed because of paperwork.

Ms. WILLIAMS. Yes.

Ms. SLAUGHTER. I am surprised. I did not realize it was almost a third. It almost seems as though it is designed to keep people from being able to make claims. And, I think one of the things probably that we could do that would be most helpful would be to try to change that enormous paper trail. I have seen the paperwork and I do not know how in the world seniors do it. I think that you provide help, do you not in filling out those papers?

Ms. WILLIAMS. Yes. In our area agency, one of the first things that we really saw was a major issue in helping people get benefits that they were eligible for. So, we have had a person on our staff since 1977 who 50 percent of her time is spent on helping people with Medigap and Medicare forms.

Ms. SLAUGHTER. Medigap is a tragedy. I think disgrace is really a better word. You mentioned that you had talked with the underwriters in your area. Was that to help screen out unscrupulous sellers of insurance?

Ms. WILLIAMS. Yes, that was part of it, and also for public education. And we would hold full-day seminars where we would do some formal educational programs in the morning, and then the afternoon, the Underwriters Association provided counselors who came and sat with people who could bring their individual policies. We also developed a form where you could write down, "This is what is under this policy." So, you could see where the holes were, and of course, the holes were long-term care, chronic care and where your duplicate services were so that people would not be paying premiums that they did not need to pay.

Ms. SLAUGHTER. I think it is past time that we can expect the beneficiaries to be able to wade their way through all of that. And Congress is going to be taking a good look at what has been done. Part of the Catastrophic Illness Bill of Layton Emory was that you had to evaluate the policies that people carry. That single issue probably worries me the most. Some of the statistics we have gotten are alarming. People who owe \$52,000 in premium costs. A friend here, who was at one point the State President of the Medical Society, told me that when his mother died, she had 16 policies. He said none of these would have done her any good. She never mentioned them to him. I do not think we have any idea of the scope of that problem or how much money people on a very limited income are paying so that they will not be a problem to anybody. And if we get anything done this year, I would very much like to

see something done about that Medigap mess. The problem is exacerbated when very famous and fine personalities on television advertise health insurance, saying to everybody, "Do not ever worry again."

Ms. WILLIAMS. Yes.

Ms. SLAUGHTER. We have also noted that a number of people get the brochures in the mail written in such a way that it looks as though it is a bill. Numbers of people send in money for what they think is a legitimate expense of theirs, only to find that they have bought yet another policy. So, I really appreciate your bringing that to our attention. We should take that 30 percent benefit rate to heart here and see about trying to solve that.

Ms. WILLIAMS. Okay. Also, in New York State, the State Insurance Commission has done a very good job in publishing for dollar of premiums spent, how much is returned to the policy holder so that people can look and say, "Well, this is a good company—that they return 94 cents on the dollar and this one only returns 50 cents on the dollar." That type of information, I think, is very helpful if people know that it is there.

Ms. SLAUGHTER. Thanks for coming.

Mr. DOWNEY. Thank you, Ms. Williams, very much.

I am going to take the first three on the next panel, Florence Carpenter from the Gray Panthers; Julian Bielski, Client, Elder Abuse Prevention Program, Regional Council on Aging; and Joyce Shearer, who is Client and Long Term Care Ombudsman Program, and testimony is to be presented by Sharon Boyd, Long Term Care Ombudsman Program of the Regional Council on Aging.

Ms. SLAUGHTER. There is Sharon.

Mr. DOWNEY. Mr. Bielski, I am mispronouncing it? Come on up, sir, if you would. Good morning. Ms. Carpenter, would you start?

Ms. CARPENTER. Sure.

Mr. DOWNEY. Thank you.

PANEL ONE—CONSUMER PERSPECTIVE, CONSISTING OF FLORENCE CARPENTER, GRAY PANTHERS; JULIAN "JIM" BIELSKI, CLIENT, ELDER ABUSE PREVENTION PROGRAM, REGIONAL COUNCIL ON AGING; JOYCE SHEARER, CLIENT, LONG TERM CARE OMBUDSMAN PROGRAM, TESTIMONY TO BE PRESENTED BY SHARON BOYD, LONG TERM CARE OMBUDSMAN PROGRAM OF THE REGIONAL COUNCIL ON AGING; JOHN ARMBRUSTER, HEALTH ADVOCATE, MONROE COUNTY OFFICE FOR THE AGING; AND MARY BODDIE, MOTION PROMOTION PROGRAM, MONROE COUNTY OFFICE FOR THE AGING

STATEMENT OF FLORENCE CARPENTER

Ms. CARPENTER. My name is Florence Carpenter, and I am retired for 2 years. I was in the field of medical social work and administrator of a home health agency. And I have worked since then, pretty much full time, as a health care advocate in the field of the needs of all people, but especially, I work with older groups. So, I would sort of like to testify a little bit about what some of my experiences have shown me.

When I worked as a medical social worker in the Emergency Department at Strong, I was the first social worker to be assigned

full-time to the Emergency Department, and that was in 1966. And that was a time at which there were many older people who were being brought into Emergency because of the fact that there just were no services available at home, and there was a shortage of nursing home beds. So, during that period, I worked a lot with trying to make arrangements for people to get care, and also to try to do what we could to develop some services for people at home.

I did see a great deal of neglect and abuse during that period, not only—we dealt, of course, in Emergency with children, but also of older people. And there was a great reluctance on the part of health care professionals to recognize abuse. It is not easy to think of this sort of thing, and I think that is one reason why we have not had more help to deal with the problem is that people do not like to admit that mothers and fathers and brothers and sisters and uncles and aunts and friends abuse others. And, it is abuse—it is abuse of helpless people, like children or older people. And older people are particularly reluctant to testify against anyone because it is family and they are all so afraid that if they do, that—and many times, they are not able, at any rate to do that.

So, I do feel—in fact, when I left Strong some 6 or 7 years after I had been there, one of the reasons I left was that I felt we needed a preventive service for adults that was not really functioning. I mean, the Department of Social Services was gearing up to deal with child abuse, which was difficult, but there really was not anything in place for elder abuse.

And as I wrote in my paper to you, we need not only someone to identify abuse, but we need another organization—not the people who identify it—but someone who now can go in and work with the situation and try to help and try to correct. It is very difficult for the one who is looked at as the policeman to go in and be the protector and to be the one who works with the family in a nonthreatening way and hopes that maybe some additional services will help to allay the problems and the situation because many times, it is the result of frustration and overburden that these things happen. And, we need to have that kind of a mechanism funded.

I left the hospital to essentially try to develop services for people at home and to try to work towards protective services. Well, it was a little early. There was not really much that I could do, so I decided to work in a broader field with the Council on Aging and I did work as the Director of the Regional Council on Aging at that point. And we did develop the ombudsman program, and we did see a great deal of services developing.

I left there, however, after awhile and I retired from that during one of my first retirements to work in the field of home health care in the rural counties because there just was not—and there—there really still is not a great deal of home health care for people in the rural counties, other than some immediate care that applies when persons have Medicare coverage and some Medicaid. But, for people who do not have Medicare or Medicaid, it is a vacuum. There just is not that kind of help available. I also became an administrator for outreach for a proprietary agency, which is a business, as you know.

So, I have worked for government and I have worked for voluntary and I have worked for business. And one of the things that we

did was try to make it possible for people in the rural and suburban areas of Monroe County to get home health services. And that is difficult because it means that the home health aide has to have a car. And home health aides do not earn that much money, and trying to drive a car is a problem.

We also worked with the system and said, "Well, we will provide transportation if you can give us, for instance, a concentration of patients in Webster or Hilton," but the system does not work that way. So, this is one of the faults, I think, of the system. It is an open bidding job for whoever takes it. So, you may have six agencies with six aides adjacent to each other, and they all have to provide transportation out to the rural or the suburban areas, and that is a waste.

Ms. SLAUGHTER. You mean franchise it, sort of, you think?

Ms. CARPENTER. Well, it is the way the system is handed out. In order to be fair to all of the agencies, it is sort of on a—you know—so, they cannot really say, "We will give you six cases in Webster, and we will give them six cases somewhere else, and then, you can provide the transportation and get your aides out to Webster. So, that is something that needs to be looked at. And I think there are other things that could be done to develop training. We had a lot of aides—because the agency I worked for was the first home health agency much longer than the others. They had a lot of aides that were trained through the CETA Program. And this meant that we had to spend a lot more time. We took people who would not make it today, but they became a real solid corps of aides who were very dependable, could do the job, but they needed extra training. They needed some help with learning how to cook and how to clean house because aides do all those things, as well as a little closer supervision. And then, eventually, they became a real solid source of supply.

So, when you say today, "We cannot find anybody," it is probably because it costs so much to train that people do not want to put this extra in, and there is not any CETA program to help with the expenses of the training. So, I think there are some answers to a lot of our problems that would really, really do a great deal to move along a real crying need which is, again, there for much more service at home.

The alternative to that is to keep building more and more nursing homes, which is just expensive and not acceptable because we proved in the access program that you can keep very sick people at home if you can provide the services for them. It wiped out the hospital backlog, which is now, again, as I understand it, building up because those services were then paid for with Medicare and Medicaid waivers. And that is a very important thing to remember that we can do it. We just have to have the will to do it.

Now briefly, I would like to make a statement about—I have been very involved in fighting the Catastrophic Care Act, and I really resent the "greedy geeser" title that has been bestowed on the elderly. I think it is a misnomer, and maybe it was used to cover up what was very poor legislation actually. The first place, the legislation itself was flawed and I will tell you why, and so was the funding. The funding—it should never be that you pick out one group of people—a very narrow band and say, "You will pay for

everything in this area." But, that is just unfair and it goes against what we have ever done before.

But in addition to that, while we like the Medicaid provisions and we are glad that they were passed, the Medicare provisions did not really give the seniors anything that they wanted or needed. We gave them additional days in a nursing home and moved the cost sharing from after a month up to the first 8 days, which when you know that the average amount that a person got under Medicare in a nursing home was 8 days, it makes you wonder what was the big benefit that we were now getting from Medicare nursing home, right?

One of the problems with the Medicare was not that it needed more days; it needed better coverage which had originally been allowed and had been gradually cut back by the government interpreting the way people would be able to get Medicare. Two hours three times a week when you early discharged patients early from the hospital is like nothing. Forget it. It means that you say to them, "Well, if you cannot get by on 2 hours three times a week and you cannot get by at home, then you go to a nursing home because you cannot stay in the hospital. And if you do stay in the hospital and you do not fit the Medicare criteria, you are going to pay for it out of your own pocket."

That is a totally unfair system, and there is not any reason why the Medicare nursing home benefit and home health care benefit should have been looked at in those ways, other than that it looked like that way, they would save money. And I do not see that as any kind of legislation that we could approve of, so I did speak to about 30 groups and explained to them what was wrong the legislation and what we should fight for and what we should not accept.

And so, I think those are the main things I really wanted to get across today. I do have a lot that is wrong with the Medigap, but I am not going to get into that right now. And the Medicaid provisions that were put in the budget, I hope to see those not only left in the budget, but funded. And once funded, I hope that the money gets spent and not just sit there and not be allocated. You know, it is fine to appropriate, but then you have got to allocate and spend it as well. Okay.

Mr. DOWNEY. Thank you, Ms. Carpenter.

[The prepared statement of Ms. Carpenter follows:]

SELECT COMMITTEE ON AGING FIELD HEARING JUNE 11, 1990
 TOPIC Unfunded programs under Title II of OAA

My name is Florence Foster Carpenter. formerly I was a Medical Social Worker assigned to the Emergency Department at Strong Memorial Hospital. I left to work for more adequate services for patients at home and for protective services for the elderly. Next I became Executive Director of the Regional Council on Aging. Many services were developed during this period, but Home Health Care and Home Support Care were still not available to many elderly, especially those in outlying areas of Monroe County and in the rural Counties of Wayne, Seneca, Ontario and Yates Counties. I worked as Outreach Administrator of Home and Family Services until I retired two years ago.

For the past two years I have been fully engaged as a "Health Care Activist" serving on many Boards and Committees and speaking to numerous groups, especially about the Catastrophic Care Act.

From 1966 to 1971, my work at Strong Hospital dealt with the large influx of elderly and disabled individuals who were in

need of services at home that were not available. Many at home deteriorated and needed nursing home beds - also not available. Some elderly caretakers themselves became patients and some caretakers who were over-burdened with no respite or help "dumped" their burdens at the hospital. Some of these patients had been neglected and some abused. These conditions often

result from frustration and inability of caretakers to handle the needs and demands of dependents.

The conditions in the community improved for a time. Many new nursing home beds were built. Proprietary Home Health Care Agencies helped to expand the at-home services. Proprietary Homes for Aged and Health Related Facilities came into existence. The ACCESS

program proved the possibility of affecting hospital back-up and provided care for many very sick patients to go home. These paid services were part of a Federal grant as a demonstration, and unfortunately were not implemented as had been hoped.

Despite many new services such as Day Care and much more home health care and programs funded by New York State, we are again seeing an increase in hospital back-up, increasing need for services at home due to increasing numbers of frail aging - the over 80 group. There are increasing needs for others as well, due to Aids, drug abuse, deinstitutionalized mental health patients - and too few to meet all these demands. SPALV

-2-

At the most recent of the Ontario County Office for Aging Advisory Committee meeting, the Director of the EISEP services reported 60 people on the waiting list (and growing) with little help of expanded funding from the state. This program offers in-home support services for frail elderly under 200% of poverty.

I believe these services should be provided so that all those needing such - no matter where they live - would be eligible to receive Income requirements have often proven a barrier to needed services for many, this includes Home Health as well as Home Support care. The term "chronic" or "long term" or not skilled" act as barriers to those who cannot afford the full cost or are not eligible for Government subsidy.

Preventive and Educational services such as Health Screening, or Health Education and Training are not generally available. We have few Gerontologists, Geriatric Psychiatrists or Geriatricians (other Countries have many). Much information about health, accidental injury and nutrition is not easily available - though it is a proven cost effective part of comprehensive health care.

Many older people do not understand their own health care coverage. It is not easy unless you know how the government and the insurance Companies (including BC and BS) interpret the language and entitlements. Many also are unaware of the health and human services that are available. Medicaid eligibility and requirements need a lawyer or person trained to interpret the rules and benefits. The Department of Social Services seems unable to adequately help in this regard.

Abuse and neglect are assigned to the DSS as Protective Services but there is a great need for funding to help with prevention and monitoring. Reporting and identifying is only a first step. It is better to have a different program to work with the family as it is less threatening.

One thing that we know is that, if an elderly person is mentally impaired, this individual is much more likely to be institutionalized. There are 3 or 4 times as many individuals with the same level of physical but no mental impairment that live at home. Most of the nursing home patients have at least some degree of mental impairment. By the same token, those who are very mentally impaired, but not physically are unacceptable to most nursing homes also. Much help is needed to help mentally impaired individuals to live safely and independently at home with others. Such situations need teaching, counselling and services appropriate to the situation. Private Pay individuals can more easily obtain these services, but not always. They also need to be available to others.

Preventing and Delaying institutionization is a must if we are going to deal with the increasing numbers of elderly and disabled in our future. Institutions are not the best choice and may not be available or affordable.

-3-

There are a number of Medicaid Initiatives, introduced in 1990 to expand Medicaid coverage of the poor. HR 3933 is the new number for the MEDICAID FRAIL ELDERLY COMMUNITY CARE AMENDMENTS. There were 5 bills that did not make it through Congress last that are also needed. These bills would broaden Medicaid coverage for pregnant women and for children. It would also permit States to provide community based services to those with developmental disabilities. One would require State Medicaid to provide Hospice benefits.

As a final note, the report of the Pepper Commission was somewhat of a disappointment due to the lack of any recommendations about funding and a lack of consensus about the services to be provided.

We have a very fractured and spotty health care system in this country with uncontrolled costs and poor results (health Status). A National comprehensive system is long overdue. Rather than more band aid approaches, we should seriously begin the debate and design a program for universal health care and for coverage of chronic long term care. The majority of Americans pay taxes for health care but receive no benefits. We have allowed the medical and hospital lobbies to design and charge for a system that is in need of control and good management. The Government has responded by over-regulation - paper work - that does not get at the problems. WE CAN DO BETTER THAN THAT - and, in the long run we will have a better system for a cost that we control.

Mr. DOWNEY. Mr. Bielski, if you would give us your testimony, please.

STATEMENT OF JULIAN "JIM" BIELSKI

Mr. BIELSKI. Good morning, everybody. I am not a very intelligent man, but I have got a little letter that I have written here. It is on paper, and I would talk about it, but I would rather read it.

Mr. DOWNEY. That is fine. Whatever makes you more comfortable.

Mr. BIELSKI. All right. My name is Julian Bielski. I am 73 years old and reside in Webster, New York. They call me Jim.

I have cared for my wife of 50 years, who has Alzheimer's disease for almost 3 years at home. During that time, we had good times and bad times. I do not know—I am a baby, I guess—

Ms. SLAUGHTER. No, not at all.

Mr. DOWNEY. No, and you are here among friends, Mr. Bielski. Just relax, and when you feel like you can go ahead, then go ahead.

Mr. BIELSKI. I always cared for her with love and concern. My wife lives now at St. John's Home where she is receiving the care and medical attention I could not give her at home.

I want you to understand what it is like to be a caregiver in a community and what difficult decisions I have to make. When my wife first began to have problems with her memory, I did not know what was wrong. She could not walk very well, and I took her to our family physician, who sent us to see a neurologist at Strong Memorial Hospital. He suggested a CAT scan, and it showed that she had a mini-stroke. Next, we went to see Dr. James Wood, a member of the geriatric medical team at the Monroe Community Hospital. He evaluated her condition and suggested that I get help or have a breakdown.

I got in touch with the Regional Council on Aging, and a social worker named Sandra Pecora helped me get Medicaid aide service for my wife and, most important, she gave me the moral support I needed to cope with the day-to-day frustrations and feelings I have had.

To see the woman you love slowly lose control of her ability to walk—she had fallen many times and I could not lift her because of an injury to my right arm and shoulder—and also her ability to remember was very stressful. Her constantly calling out for me, wandering—wandering in the middle of the night and to understand—unless you have gone through it—that many times, I angrily yelled at her, but I regretted it later. I love her very much. Friends and neighbors do not visit us in the past, and I had to be around all the time.

But thanks to the aide service I got from the Regional Council on Aging, I was able to work things out. After Mrs. Pecora left Regional Council, Art Mason and Thelma Nemeroff got me respite time at St. John's Home with the help of a social worker, Patty Wallon from St. John's. Finally, Ms. Wallon called me and told me that there was a—had a permanent room for my wife, Julie. I gave thanks—give thanks to them for all their help and Mr. Vincent Park—he is the Administrator at St. John's—for accepting her.

I, myself, have physical problems. In the past years, I have had heart attacks, cancer, injuries and operations. Two months ago, I had an arthroscopy operation on my knee, which I could not have done before while taking care of my wife. How much can I cope with?

Therefore, I urge you to provide money and support for the Older Americans Act. Perhaps with the passage of this legislation, other seniors will not have to go through what my wife and I had to endure. Those of us who had given so much to this country—I was in the Navy in World War II, and my daughter was only 3 months old when I had to go in. So, my wife had taken care of her over the years. Need this help if we are going to live the rest of our lives with dignity. Thanks for hearing me out. I am sorry I broke out like this.

Mr. DOWNEY. Oh, you have nothing to apologize, except your opening statement when you said you were not a smart man. We do not like the subcommittee being lied to.

Mr. BIELSKI. I only got 1 year of high school. That is all. But, I urge you to help these poor people because if you want to see something, go to St. John's Nursing Home on the second floor in Building 72 and see these Alzheimer patients, what goes on. It breaks your heart.

Mr. DOWNEY. It certainly—

Ms. SLAUGHTER. And what happens to the caregivers as well.

Mr. DOWNEY. That is right.

Ms. SLAUGHTER. Because it never stops. It is 24 hours a day, 7 days a week.

Mr. BIELSKI. They have very good nurses there, and they give her good care, which I could not at home. She fell in the tub on me one time when I was giving her a shower. I could not get her up. I had to get a neighbor to help me up with her. So, we need—we need more care for the caregivers, too.

Ms. SLAUGHTER. More research money would not hurt either.

Mr. BIELSKI. Right. So, I am sorry.

Ms. SLAUGHTER. Not a bit.

Mr. DOWNEY. You have nothing to apologize for.

Mr. DOWNEY. Ms. Boyd, if you would proceed.

Ms. BOYD. Sure.

Mr. BIELSKI. One request.

Mr. DOWNEY. Certainly.

Mr. BIELSKI. May I take a photo? I have not been with any dignitaries before.

Mr. DOWNEY. Well, I am not sure you are yet.

Ms. SLAUGHTER. You have to wait for that.

Mr. DOWNEY. We will wait to get the Governor here. Yes, you certainly can. Absolutely. I will take my glasses off when you go to take that picture, too. Ms. Boyd, if you would proceed while Mr. Bielski is taking photographs, we will try and look as candid as possible.

Mr. BIELSKI. Okay.

Mr. DOWNEY. Thank you.

STATEMENT OF JOYCE SHEARER, AS READ BY SHARON BOYD

Ms. Boyd. Good morning. I would like to read to you today a letter written by Joyce Shearer. Joyce's mother was a consumer of long term care and was a client of the Monroe County Long Term Care Ombudsman Program. Joyce herself wanted to be here today to give this testimony, but is seriously ill and has asked that I read it on her behalf. Before I begin, let me share with you her note that accompanied this testimony.

"My dear friend, here is my testimony. It was difficult to go back over those painful days, but I still live at peace knowing we did all we could for this great lady. This story came right from my heart. I pray that it may give others hope and realize that programs like yours are much needed and appreciated."

Here is Joyce's testimony. "I would like to tell the story of a lady who fell between the cracks of the system. At age 84, my widowed mother was accepted as a resident in an adult home. At first, it was a difficult move for her. In time, however, she adjusted to this new, unfamiliar way of life. She enjoyed new friendships and became very active in the home's activities, including being an active member of the residents' council.

"As a member of the residents' council, she was influential in introducing several new ideas to the council. These ideas were adopted and improved some of the rules of the home. Because of her positive attitude, she was asked by the administrator if she would consider greeting and counseling new arrivals. She graciously accepted, knowing from experience that those first days were depressing and frightening. Many residents came to talk to this lady, who helped them through their troubled times.

"During the next 2 years, Mother spent down her savings much quicker than anticipated. This was due to high medical costs and three raises in her rent. During that 2-year period, between her Social Security checks and life's savings, Mother paid the adult home \$26,000 in room and board. Becoming concerned about her depleting resources, I decided to do something about Mother's financial situation. I went to Social Security first and applied for SSI for Mother. She was denied. She was \$9 a month over income. Next, I applied to Medicaid for help with Mother's medical bills, which were extremely high. She was accepted for this.

"I returned to the adult home administrator, and after presenting our new concern, was told Mother would not be able to stay there unless she paid her room and board in full. They then suggested I look for another place for my Mother. I was appalled at this new insensitive attitude displayed by the administrator upon learning about my Mother's financial circumstances. It had been my understanding from the very beginning that after her money had run out, she could still live there on SSI. I had not only been deceived by the adult home, but Social Security had also failed to meet her needs.

"I was lost and did not know where or who to turn to. Mother's spirits were dropping, and her health generally started to fail. Luckily, an administrator of another adult home suggested I contact Sharon Boyd, Director of the Monroe County Long Term Care

Ombudsman Program at the Regional Council on Aging. It turned out to be the best piece of advice I ever took.

"I contacted Sharon and voiced my concerns to her. I was immediately assured that I did not have to stand alone. She explained my Mother's rights to me. She counseled me every step of the way through the next trying weeks. She found an attorney for Mother. She encouraged me to reapply to Social Security for SSI, and this time, we were granted help. Sharon gave me the courage to stand up and fight for my Mother's well being. We lost our case because the judge turned a deaf ear to our insistence that we had been deceived by the adult home. After the court's decision, Mother lost all her hope, and we, at her request, gave up any future appeal. She was evicted and had no place to go. Once again, the Ombudsman Program came to her rescue. Another home was found for Mother that accepted SSI.

"Mother spent the rest of her days in her room alone, depressed, unwilling to take part in any activities. Her health rapidly failed mentally and physically.

"I am deeply troubled as to where our elderly are going and what they have to endure in the so-called "Golden Years." It appears that when your monies are gone, there are few who care about your circumstances. Only because of the Ombudsman Program was my Mother able to spend her last days with some kind of dignity. She and I both saw there was someone out there who cared. This program is sincerely appreciated."

Mr. DOWNEY. Thank you, Ms. Boyd. Do you have any questions, Louise?

Ms. SLAUGHTER. I'd like to make more of a statement than anything else. First, I work with Florence and Sharon a lot. It is nice to get to know Mr. Bielski. But, I really think that with their help and the kind of work that we are doing here, we are going to be able to find some of the answers to long term care. Sally Trafton is back there somewhere. She has headed up a group that has been meeting for 3 years now and working on the very things you are talking about.

Transportation is critical. I have a constituent in Honeoye Falls who is eligible for help, and she cannot get any because there is no bus service out there and people on a low wage cannot afford to get out there.

I understand, too, that there are some training requirements in New York. Mr. Jaffee, we could probably talk to you about some of these. That if you move the patient, you almost have to be a physical therapist. And that numbers of people could be trained to do that kind of work more easily and much less expensively. And those are other things that we are going to be looking into as well.

I sure am grateful to you—not just for today, but for everyday.

Ms. BOYD. Thank you.

Mr. BIELSKI. I agree because I live in Webster, and I had a tough time trying to get an aide for my wife.

Ms. SLAUGHTER. Because transportation is so difficult.

Mr. BIELSKI. She could not drive, and a couple of times, she came in a taxi.

Ms. SLAUGHTER. And they cannot afford that because their wages are not high enough.

Mr. BIELSKI. Well, I appreciate it.

Mr. DOWNEY. We appreciate your testimony, Mr. Bielski and Ms. Boyd and Ms. Carpenter. Thank you very much.

We are going to next hear from John Armbruster, who is a Health Advocate from Monroe County Office for the Aging; and Mary Boddie, Motion Promotion Program—I almost thought that was a misprint—Monroe County Office for the Aging; and Sharon Boyd, who has already testified—I am sorry, Thelma—just those two? Ms. Broddie. Oh, she is here. Boddie, I am sorry. Boddie, all right. If I keep saying it, I may get it right. Mr. Armbruster, if you would start.

STATEMENT OF JOHN ARMBRUSTER

Mr. ARMBRUSTER. Chairman Downey, Representative Slaughter, welcome to Monroe County and thank you for inviting me to testify. I will address one segment of the education and promotion issue—that of assistance to older Americans in understanding, claiming and evaluating benefits of competing Medigap health insurance policies.

Here in Monroe County, we have a corps of dedicated and trained volunteer counselors in a joint venture organized and coordinated by the Monroe County Medical Society, American Association of Retired Persons and the Monroe County Office for the Aging, with the Monroe County Office for the Aging providing a half time staff person, office space and phone line to coordinate the total effort.

During our first year of operation, over 1,200 personal counseling sessions have been held, plus many talks to small groups in the community. Fortunately, with the volunteer guidance of the Ad Council, exposure at health fairs and other community activities, plus referrals from local health care providers and insurers, we have been able to locate and help at least this small portion of the total need.

Some of our clients are new to the system and have very basic concerns, such as, what is supplemental insurance and why do I need it? The underlying perception frequently seems to be, "I already have Medicare coverage. Why should I pay for more insurance?" Or, "Sure, I do have a supplemental policy, but with all I hear and read about skyrocketing medical care costs, I should probably buy another." We do encounter clients at both ends of the dilemma. Our organization is trained and available to explain these pitfalls to individuals and groups. However, because many do not recognize they may have these problems, there is no motivation for them to seek our assistance. Somehow, this problem has to be brought to the attention of these people.

The logical follow-up question a client will have is, "Okay, now that I understand what this supplemental insurance is all about and how one good comprehensive policy can benefit me, what is available?" That is another broad-based need for education.

Many clients approach us with a knowledge of what is available and they question, "Which one is best?" Our counselors cannot and do not make recommendations of specific insurance policies; but we do have an obligation to provide them with the tools to build the

coverage that best fits their needs. A computer software program is enabling us to pilot a comparison of Medicare Gap coverage provided by specific supplemental insurance programs. In addition to helping the client decide which policy is best for him or her, it also addressed the question of, "what is enough?", since areas of duplication become obvious. The client can decide in a setting free of sales hype or coercion which policy is best for him or her and avoids paying for duplicate coverage.

Most of the clients we serve approach us because of difficulty understanding our coverage or difficulty accessing the reimbursement or appeals process. The husband of a recent client had prescription drug coverage following hospitalization. His prescription claims have been reimbursed for several months, and then suddenly, he received a rejection notice that payment was disallowed because of a gap in his usage. She called us for help. She wondered if her husband qualified for any other insurance for prescription coverage only. The counselor's first thought was that the original rejection did not seem valid, and by interceding for her, was able to find that the client's nonsequential filing caused the insurer's computer to issue a rejection for discontinuity. She was reimbursed and avoided purchasing unnecessary prescription only insurance. Another evidence of the need for Medicare supplemental insurance counseling and education.

A call came in to the hotline late one Wednesday afternoon asking for help with claims filing. The client, from Arkansas, was hospitalized while visiting in our area. Upon leaving the hospital, he noticed our hotline number. He said he was planning to leave for home that weekend and knew of no similar service back home and wondered if we might be able to help him. I contacted one of our counselors who served at a site near the home of the client's host, and they met Saturday morning, initiated what was possible and then discussed subsequent steps. Yet another example of a single need for education and promotion met and a perception of many more going unattended.

A man called quite distraught to say his wife had been dropped by her supplemental insurance company. He said she had many claims that were covered, but today, he received a rejection saying his wife was not covered under this policy. His comment was that he guessed she was costing too much, so they dropped her. The counselor, contacting the insurance company's subscriber services group, found her coverage was intact. The rejection was caused by a misspelled subscriber name. I am sure he could have accomplished the same by going direct to the carrier if he had enough knowledge of the system to have the confidence to overcome the inherent intimidation.

A frail elderly couple with no relatives or representatives was referred to us for help with claims filing. The wife had been a semi-invalid for some years, and the husband, who had been handling all their claims filing recently had a stroke. He has since died, and the wife is now institutionalized, and we continue to provide service. In this case, education and promotion would have been of little help for them. However, outreach efforts need to be focused on the well and near well community to alert them and the prospective representatives to a possible ultimate need.

These are but a few of our contacts with people with supplemental insurance problems. These people, who may be deprived of the knowledge of how to work within the Medicare supplement health process because of intimidation, frustration or physical and emotional reclusion, could be well served by emphasis on education and promotion of the many facets of the program.

Unfortunately, the entire health care reimbursement and coverage system is unnecessarily complicated, too costly and only very poorly covers long term care. Although not the subject of this hearing, these examples just cited also point to a crying need for some type of comprehensive national system of health coverage that would be, at the same time, more simple and more just.

Returning to the issue at hand—what can be done to support the need for education and promotion identified in these examples? Working within the existing system and with some funding through local agencies on aging. The application of skills search inventories being compiled by organizations, such as the American Association of Retired Persons, to provide a vast array of retired experiences available across the Nation for appropriate volunteer opportunities. And finally, a nurturing of cooperation across geopolitical and organizational lines to utilize the best parts of programs already in existence.

If we were starting this program today, the State and county funds would not be available. For communities not now organized, it would be extremely difficult, nearly impossible, to replicate this model without the funding which here was provided by the Office for the Aging.

I feel we have proved this type of health education and promotion for older Americans is needed and can be provided effectively. I urge consideration of its expansion through the funding provision introduced by Representative Louise Slaughter during the reauthorization of the Older Americans Act.

Thank you for the opportunity to present this testimony.

Mr. DOWNEY. Thank you, Mr. Armbruster.

[The prepared statement of Mr. Armbruster follows:]

JOHN ARMERUSTER
HEALTH ADVOCATE, MONROE COUNTY OFFICE FOR THE AGING

Chairman Downey, Representative Slaughter, Committee Members: Welcome to Monroe County and thank you for inviting me to testify at this House Select Committee on Aging's Subcommittee on Human Services, to offer evidence of the need for federal funding for the Health Education and promotion provision of the Older Americans Act, as introduced by Representative Slaughter, when the act is reauthorized in 1991. I will address one segment of the education and promotion issue - that of assistance to older Americans in understanding, claiming and evaluating benefits of competing medigap health insurance policies.

Here in Monroe County we have a corps of dedicated and trained volunteer counselors in a joint venture organized and coordinated by the Monroe County Medical Society, American Association of Retired Persons and the Monroe County Office for the Aging. Each organization contributes of their strengths and continues to offer resources, with the Monroe County Office for the Aging providing a half-time staff person, office space and phone line to coordinate the total effort.

The number of volunteer counselors, retired men and women, most of Medicare age, with commitment to providing a minimum of four hours of counseling service per month for one year, varies between forty and fifty. During our first year of operation over 1,200 personal counseling sessions have been held, plus many talks to small groups of seniors. Reaction of these audiences demonstrates how small a portion of people in need of our services is represented by the 1200 served, and more importantly - how much more needs to be done to let potential clients know this free service exists to help them with their concerns about Medicare supplemental health insurance plans. Fortunately, with the volunteered guidance of the Ad Council, exposure at Health Fairs and other community activities plus referrals from local health care providers and insurers we have been able to locate and help at least this small portion of the total need.

I'd like to share with you some examples of the needs, many of which would have gone unmet had it not been for this effort. The larger concern for our focus is how many more are out there, unaddressed due to the lack of knowledge of our volunteer services? Or in other communities due to the lack of a program like ours?

Some of our clients are new to the system and have very basic concerns such as - what is supplemental insurance and why do I need it? Their underlying perception frequently seems to be - I already have Medicare coverage, why should I pay for more insurance? Or, sure, I do have a supplemental policy but with all I hear and read about skyrocketing medical care costs, I should probably buy another. We do encounter clients at both ends of the dilemma, some who could probably afford the cost but do not recognize the need for a supplemental policy and others become over-insured by purchasing additional supplemental policies, not recognizing they are likely to be completely duplicative in coverage and only one

will pay. Our organization is trained and available to explain these pitfalls to individuals and groups. However, because many do not recognize they have these problems there is no motivation for them to seek our assistance. Somehow the problem has to be brought to the attention of these people.

The logical follow-up question a client will have is, "O.K. now that I understand what this supplemental insurance is and how one good comprehensive policy can benefit me, what's available?".... Another broad-based need for education! One of our clients, in her 70's, lost supplemental coverage under her husband's pension benefits program, due to divorce. Her settlement included provision for coverage at least as good as what she had. She did not pursue this immediately, but when she did she found an HMO that was appropriate; however, with no current open-enrollment period, she had to wait ten months for coverage. Our counselor was able to help her search for appropriate interim coverage.

Many clients approach us with a knowledge of what's available and the question, "which one is best"? Our counselors cannot and do not make recommendations of specific insurance policies. This is a personal decision involving insight that only the client has. However, we do have an obligation to provide them the tools to build the coverage that best fits their needs. The Monroe County Office for the Aging purchased a computer software program which is enabling us to pilot a comparison of Medicare "Gap" coverage provided by specific supplemental insurance programs. While this program isn't intended to make the final decision of what insurance to buy, it does highlight differences. In addition to helping the client decide which policy is best for him/her, it also addresses the question of "what's enough", since areas of duplication become obvious. The client can decide, in a setting free of sales hype or coercion, which policy is best for him/her and avoids paying for duplicate coverage.

During our first two months of piloting this program, we have been able to provide this free comparison summary to over 60 callers. Here again, a meaningful and sincere but, in perspective, inadequate approach to a gigantic need. How many more seniors could be served if they were aware of their problems and knew of our programs?

Most of the clients we serve approach us because of difficulty understanding their coverage or difficulty accessing the reimbursement or appeals process. The husband of a recent client had prescription drug coverage following hospitalization. His prescription claims had been reimbursed for several months and then suddenly he received a rejection notice that payment was disallowed because of a gap in his usage. She, the client, called us for help. She said she heard about EPIC (New York State's Elderly Pharmaceutical Insurance Coverage) and wondered if her husband qualified for coverage or if any other insurance was available for prescription coverage only. The counselor's first thought was that the original rejection did not seem valid and by interceding for

her was able to find that the client's non-sequential filing caused the insurer's computer to issue a rejection for discontinuity. She was reimbursed and avoided purchasing unnecessary "prescription only" insurance. Another evidence of the need for Medicare supplemental insurance counseling and education.

A call came in to the hotline late one Wednesday afternoon asking for help with claims filing. The client, from Arkansas, was hospitalized while visiting in our area. Upon leaving the hospital, he noticed our hotline number and offer of free help with Medicare and supplemental insurance claims filing. He said he was planning to leave for home that weekend, knew of no similar service "back home" and wondered if we might be able to help him. I contacted one of our counselors who served at a site near the home of the client's host and they met Saturday morning, initiated what was possible and then discussed subsequent steps. The counselor gave his address and phone number in case any more help is needed. Yet another example of a single need for education and promotion met and a perception of many more going unattended.

A man called, quite distraught, to say his wife had been "dropped" by her supplemental insurance company. He said she had many claims that were covered but today he received a rejection saying his wife was not covered under this policy. His comment was that he guessed she was costing too much so they dropped her. The counselor told him that this could not have been the reason for the rejection and said he'd check into it. Contacting the insurance company's subscriber services group he found her coverage was intact. The rejection was caused by a misspelled subscriber name. Although this was a single, easily corrected incident, the subscriber turned to our free service for help. I'm sure he could have accomplished the same by going direct to the carrier if he had enough knowledge of the system to have the confidence to overcome an inherent intimidation. He worked with us before and he felt "safe" with us. How much more effective the total system would be if a promotion and educational outreach program would generate the same feeling of security for direct consumer - insurer contacts.

A frail, elderly couple with no relatives or representatives was referred to us for help with claims filing. The wife had been a semi-invalid for some years and the husband, who had been handling all their claims filing recently had a stroke. He has since died and the wife is now institutionalized and we continue to provide service. In this case, education and promotion would have been of little help for them; however, outreach efforts need to be focused on the well and near-well community to alert them, and their prospective representative, to a possible ultimate need.

These are but a few of our contacts with people with supplemental insurance problems. They are representative of the types of problems encountered by the approximately 24 million older Americans that AARP says have turned to supplemental insurances.

These people, who may be deprived of the knowledge of how to work within the Medicare supplemental health insurance process because of intimidation, frustration, or physical and emotional reclusion, could be well served by emphasis on education and promotion of the many facets of the program. Indeed, they deserve to know what's available and how to cope with this growing threat of inadequate resources to meet mushrooming medical expenses.

Unfortunately, the entire health care reimbursement and coverage system is unnecessarily complicated, too costly and only very poorly covers long term care. Although not the subject of this hearing, these examples just cited also point to a crying need for some type of comprehensive national system of health coverage that would be at the same time more simple and more just.

Returning to the issue at hand - what can be done to support the need for education and promotion identified in these examples? Working within the existing system some funding through local Area Agencies on Aging could provide the pilot light for igniting and maintaining the flame of volunteerism already glowing in communities. The application of skills search inventories being compiled by organizations such as the American Association of Retired Persons could provide the fuel to rekindle the embers of a vast array of retired experiences available across the nation for appropriate volunteer opportunities. And finally, a nurturing of cooperation across geo-political and organizational lines to utilize the best parts of programs already in existence. Yes, the mandate to the Area Agencies on Aging would require funding. However, I feel the seed of outreach would provide a bountiful harvest of health education and promotion.

In our community we were able to develop our program because of the confluence of several factors two years ago:

- A willingness of the Monroe County Medical Society and the American Association of Retired Persons to commit time, training and some funding.
- Phenomenal ability to recruit volunteers. A task which agencies have found more difficult every year.
- Willingness of Monroe County to cover the cost of one-half a staff member of the Office for the Aging and related expenses.
- New York State funds to purchase software for comparing supplemental insurance policies.

If we were starting this program today, the State and County funds would be unavailable. For communities not now organized it would be extremely difficult, nearly impossible, to replicate this model without the funding which here was provided by the Office for the

Aging.

I feel we have proved this type of health education and promotion for older americans is needed and can be provided effectively. I urge consideration of its expansion through the funding provision introduced by Representative Louise Slaughter during the 1987 reauthorization of the Older Americans Act.

Thank you for the opportunity to present this testimony.

pf/wp

Ms. SLAUGHTER. Thank you. This is wonderful.
Mr. DOWNEY. Mrs. Boddie.

STATEMENT OF MARY BODDIE

Ms. BODDIE. Good morning, Chairman Downey, Congresswoman Slaughter and other members of the panel. I am pleased and honored to be here this morning. I am an older American, and I would like to share with you this morning the story of the exercise class that I am a part of.

I take part in an exercise class called "Motion Promotion" offered by the Arthritis Foundation by a fantastic teacher who herself is a senior citizen. The class is taught at Montgomery Center. Funds for this, I understand, come from the Office of the Aging. We have two classes a week, and some of us go to aquacize class taught by the same instructor. This class has made such a difference in the lives of the women who take it, and we are all women. I want to tell you about them.

We have one woman in the class who never did any exercise, and she was very critical of everything. Now, she comes regularly and she laughs a lot more. You see, this class makes a difference in more than just our physical health. As part of this class, we get to singing and we hug each other at the end. It has helped a lot of the women to express themselves and feel good about themselves.

We have a mother and daughter who come together to class. Yes, they are both over age 60. And after class, they hug each other, just like everyone else. It turns out, though, that they are not so comfortable hugging each other outside of the class, so you can see how the class has helped people to express their feelings.

One woman in the class comes all the way from the other side of town and has to bum a ride back from somebody, but she comes every time. Another has her husband drive her and pick her up, and they live quite a ways away. She comes regularly, too.

A couple of people in the class used to come into the center, but they would never join in and do anything. Now that they have gotten involved in the exercise class, they join a lot more. This class is not only helping their bodies to move, but helping their minds to loosen up and express themselves.

One woman in the class recently came here to live from Detroit, and since then, she has had brain surgery. She told our senior director one day, "I have got to get up—I have to go to exercise today." So, you see, the exercise class has given her a reason to get up in the morning.

As for me, I am an active person, and I have always had to take good care of my body. I come together with people at the center. Also, I come in for the hugging process.

So, I hope this helps you understand all the ways that these exercise classes help people. They help their bodies, their souls and their minds.

Thank you.

Mr. DOWNEY. Thank you, Mrs. Boddie. Now, I think we have a short video presentation of the Motion Promotion Program, which I think we would like to see.

Ms. BODDIE. May I say that Mrs. Louis says that it is going to be quite lengthy, so if, perhaps, after lunch, it can be shown.

Mr. DOWNEY. That is fine.

Ms. SLAUGHTER. Your class is here, is not it?

Ms. BODDIE. Yes, all of my class. This is my instructor, Mrs. French.

Ms. SLAUGHTER. Which one? Where is Mrs. French?

Ms. BODDIE. Right there. Stand up, Mrs. French. And then, the other members of our class in our audience. Would they all stand please, for me.

VOICE. This lady is very active.

Ms. SLAUGHTER. Eighty-seven? I cannot believe it.

Mr. DOWNEY. I cannot believe that. Do you have any questions?

Ms. SLAUGHTER. No.

Mr. DOWNEY. Mr. Armbruster and Mrs. Boddie, thank you very much. And to all the members of the exercise class, you look in marvelous shape. Maybe you can transfer some of that elixir to the Members of Congress who probably richly need and use this sort of therapy.

Now, we are going to hear a provider perspective, Sharon Boyd, Director of Long Term Care Ombudsman Program, who testified before. Sharon, if you would come back. And Thelma Nemeroff, who is the Director of the Elder Abuse Prevention Program, Regional Council on Aging.

After this panel, we are going to take a break for an hour, and then Congresswoman Slaughter will be receiving testimony in the afternoon, and I will be going out and taking a look at some of the programs, so we can maximize our time here in Rochester.

If you would start, please.

PANEL TWO—PROVIDER PERSPECTIVE, CONSISTING OF SHARON S. BOYD, DIRECTOR, MONROE COUNTY LONG TERM CARE OMBUDSMAN PROGRAM, REGIONAL COUNCIL ON AGING; THELMA NEMEROFF, DIRECTOR, ELDER ABUSE PREVENTION PROGRAM, REGIONAL COUNCIL ON AGING; CONNIE BOYD, DIRECTOR, GENESEE COUNTY OFFICE FOR THE AGING; MARGUERITE NICKEL, COMMUNITY HEALTH NURSE, MONROE COUNTY HEALTH DEPARTMENT, MONROE COMMUNITY HOSPITAL, ALZHEIMER'S FAMILY OUTREACH PROGRAM; TERESA A. GALBIER, DIRECTOR, DEVELOPMENTALLY DISABLED ELDERLY PROGRAM, REGIONAL COUNCIL ON AGING; PAT CAMPBELL, R.N., NURSE CONSULTANT, MONROE COUNTY OFFICE FOR THE AGING; JOANNE GREENE, COUNSELOR, ELDER COUNSELING PROGRAM, CATHOLIC FAMILY CENTER; AND MARTA BERMUDEZ, ST. MARY'S HEALTH SCREENING PROGRAM, ST. MARY'S HOSPITAL

STATEMENT OF SHARON BOYD

Ms. Boyd. Good morning. I want to thank Congresswoman Slaughter for the opportunity to express my concerns today about unfunded Title III programs under the Older Americans Act, specifically, the Long Term Care Ombudsman Program.

The Long Term Care Ombudsman Program began in 1972 with Federal grants to select States to develop model programs for nurs-

ing homes. Congress saw this need when investigative reporters of the late 1960's and early 1970's exposed the horrendous conditions found within many nursing homes throughout the United States. It was a case of an industry experiencing rapid growth and lagging Federal and State regulations. In 1978, under the Comprehensive Older Americans Act Amendment, the program was legislatively extended to all States. And by 1981, legislation included all long term care facilities, in addition to nursing homes.

In New York State, 100,000 of our elderly citizens reside in nursing homes, 25,000 reside in adult homes and thousands more in enriched housing and board and care homes. These are our most frail and vulnerable citizens. Not only have they lost most of their independence, they have impoverished themselves as well. These fellow citizens must rely on someone else to do for them what they used to do for themselves and others. Their total dependence upon the staff of the facility often makes them hesitant to share concerns or complaints against a caregiver or the system. Isolation from families and other outside support systems also makes patients afraid of the consequences of speaking out.

The community link that opens the door and gives these citizens the opportunity and the confidence to have their voices heard is the ombudsman. Here is a person who visits weekly—sometimes more often—for the sole purpose of listening and being their advocate. Ombudsmen do this and do it exceptionally. In New York State, we have been doing this since 1977, and here in Monroe County, we have been patient advocates since 1978. Unfortunately, the program is funded for fewer staff than several years ago, due to overall funding constraints. Nonetheless, this past year, one full-time director and 27 volunteer ombudsmen made 3,777 client contacts, served 2,994 unduplicated program participants within 34 long term care facilities and handled 406 community-based complaints and requests for information.

I am proud of the work that I and my ombudsmen do, but it is not enough. We have a mandate and the legal right of access to all 49 nursing homes and adult homes in this county. We also have that same mandate and legal right of access to the consumers of long term care within enriched housing units and board and care homes, but we cannot even consider serving them. Residents in nursing homes and adult homes alone number almost 7,000 in this county. Our facilities range from 14 beds to facilities with over 600 beds. Our clients range from those who need only minimal assistance with their activities of daily living to those in advanced stages of dementia, cancer, Parkinson's, et cetera.

We have handled cases this past year involving adult home evictions; the challenging of a guardianship for two developmentally disabled sisters; the overuse and abuse of restraints; the terrorization and intimidation of a non-Englishspeaking resident by an administrator; requests for special diets and menus; unanswered call lights resulting in residents waiting for more than 30 minutes for assistance; and issues involving residents' rights, and in particular, being treated with dignity and respect. There were many more issues and concerns addressed by the local program this past year too numerous to mention.

If this sounds like a harsh indictment of our area's long term care facilities, that is not my intent. We are fortunate within this community to have excellent facilities administered by competent and caring staff. However, the very nature of long term care and all the variables intrinsic in its delivery to the frailest of our citizens will lead to the types of complaints I just mentioned.

This past March, the Quality of Care Commission issued its report on Adult Homes in New York State. I had the opportunity to travel to Albany and view the 30-minute slide presentation on those findings. What I saw sickened me. Granted, most of the adult homes that were grossly out of compliance were downstate, but it did demonstrate to me the need for advocates within the long term care system is as great as ever. Many substate Ombudsman Programs, however, cannot place ombudsmen within adult homes because of inadequate funding. On the other hand, some programs only place ombudsmen in adult homes, leaving nursing home patients unserved because of the same funding constraints.

With the reauthorization of the Older Americans Act in 1987 and the separate authorization for appropriations for the Long Term Care Ombudsman Program, we substate directors felt hopeful that finally, adequate funding would be coming to the State and to local programs for administering the only program within the Older Americans Act specifically targeted to meet the needs of long term care facility residents. That hope was quickly dashed when it was learned that the Ombudsman Program was subject to the trigger mechanism, thus relegating it to second class citizen status.

So, here we are. A needed program with a record of success. A program able to integrate highly trained and skilled volunteers into a complaint resolution process that can and does involve providers, public agencies, social agencies, regulatory agencies, et cetera, and a program that oftentimes is the only link that a long term care consumer has with the outside.

Our rapidly aging population, particularly among the old old makes long term care one of the most crucial issues for Congressional concern. As we move into the 1990's and Congress concentrates its efforts on the financing of this care, we cannot forget the people themselves. They are our mothers, our fathers, our grandmothers and our grandfathers. We must continue to provide them an avenue and a mechanism for their voices to be heard.

Long term care advocacy is too important to leave it to possible funding if there is an increase of more than 5 percent over the previous year's Older Americans Act funding level. Long term care advocacy must also be expanded with adequate funding to cover hospital and home care. Our legislators began to give consumers of long term care a mechanism to have their voices heard 13 years ago. We must not weaken it, or we will lose it, and there is nothing waiting in the wings to take its place. Thank you.

[The prepared statement of Ms. Boyd follows:]

OMBUDSMAN PROGRAM TESTIMONY

SHARON S. BOYD, DIRECTOR

MONROE COUNTY LONG TERM CARE OMBUDSMAN PROGRAM

FIELD HEARING

REAUTHORIZATION OAA

REGIONAL COUNCIL ON AGING

JUNE 11, 1990

Good Afternoon. I want to thank Congresswoman Slaughter for the opportunity today to express my concerns about unfunded Title III Programs under the Older Americans Act, specifically the Long Term Care Ombudsman Program.

The Long Term Care Ombudsman Program began in 1972 with Federal grants to select states to develop model ombudsman programs for nursing homes. Congress saw this need when investigative reporters of the late 1960's and early 1970's exposed the horrendous conditions found within many nursing homes throughout the United States. It was a case of an industry experiencing rapid growth and lagging Federal and State regulations. In 1978 under the Comprehensive Older Americans Act Amendments, the Program was legislatively extended to all states; and by 1981, legislation included all long term care facilities in addition to nursing homes.

The Long Term Care Ombudsman Program can vary from state to state depending on the administering agency. Most Programs are part of the state agency on aging and are independent from the facilities they monitor. The duties and powers of the Long Term Care Ombudsman are to investigate complaints on behalf of patients, their families and staff. The emphasis is on being a patient advocate and protecting their rights. The Program is used mainly by patients, but nursing home and adult home administrators and staff also rely on the Program to resolve problems involving difficult patients and families. The nature of ombudsman cases relate to the action, inaction, or decisions of administrators and staff of the facilities as well as the action, inaction and decisions of public agencies and social service agencies which may adversely affect the health, safety, welfare or rights of the patients. Many of the ombudsmen are volunteers as the law supports the training and use of volunteers. Most states have an average of three paid professional full time staff in the state ombudsman office with the balance of paid and volunteer staff varying from state to state. Currently in New York State there are four paid full time staff in Albany. Our substate Programs (those within the counties) vary from there not being one at all to one with five paid staff and an annual budget of \$100,000.

In New York State 100,000 of our elderly citizens reside in nursing homes, 25,000 in adult homes and thousands more in enriched housing and board and care homes. These are our most frail and vulnerable citizens. Not only have they lost most of their independence they have impoverished themselves as well. Gone are the familiar homes or apartments they loved; gone are the comforting personal items like knick-knacks, pictures, dishes, collectibles that held so many memories; and gone is the ability and freedom to just walk into the kitchen at 3 a.m. and make a cup of tea or turn on television or read at 4 a.m. when you can't sleep. These fellow citizens must rely on someone else to do for them what they use to do for themselves and others. Their total dependence upon the staff of the facility often makes them hesitant to share concerns or complaints against a caregiver or the system. Isolation from families and other outside support systems also makes patients afraid of the consequences of speaking out. The community link that opens the door and gives these

citizens the opportunity and the confidence to have their voices heard is the ombudsman. Here is a person who visits weekly, sometimes more often, for the sole purpose of listening and being their advocate. This community advocate comes into the facility free of the encumbrances of being family, provider or member of the medical profession. That's important. It's important because the advocate must look objectively at each concern brought to his or her attention. Resolutions have to be supported by family, provider and medical staff to be successful.

Long Term Care Ombudsmen can do this - and do it exceptionally. In New York State we've been doing this since 1977; and here in Monroe County we've been patient advocates since 1978. Unfortunately, the program is funded for fewer staff than several years ago due to overall funding constraints. Nonetheless, this past year one full time Director and 27 volunteer ombudsmen made 3,777 client contacts, served 2,994 unduplicated Program participants within 34 long term care facilities and handled 406 community-based complaints and requests for information. I am proud of the work that I and my volunteer ombudsmen do; but it isn't enough. We have the mandate and legal right of access to all forty-nine nursing homes and adult homes in this county. We also have that same mandate and legal right of access to the consumers of long term care within enriched housing units and board and care homes but can't even consider serving them. Residents in nursing homes and adult homes alone number almost seven thousand in this county. Our facilities range from fourteen beds to facilities with over six hundred beds. Our clients range from those who need only minimal assistance with their activities of daily living to those in advanced stages of dementia, cancer, Parkinson's, etc. We've handled cases this past year involving adult home evictions; the challenging of a guardianship for two developmentally disabled sisters; the overuse and abuse of restraints; the terrorization and intimidation of a non English-speaking resident by an administrator; requests for special diets and menus; unanswered call lights resulting in residents waiting for more than thirty minutes for assistance; and issues involving residents' rights, in particular being treated with dignity and respect. There were many more issues and concerns addressed by the local Program this past year too numerous to mention. If this sounds like a harsh indictment of our area's long term care facilities, that's not my intent. We're fortunate within this community to have excellent facilities administered by competent and caring staff. However, the very nature of long term care and all the variables intrinsic in its delivery to the frailest of our citizens will lead to the types of complaints I just mentioned.

This past March the Quality of Care Commission issued its report on Adult Homes in New York State. I had the opportunity to travel to Albany and view the thirty minute slide presentation on those findings. What I saw sickened me. Granted, most of the adult homes that were grossly out of compliance were downstate, but it did demonstrate to me and the other substate Director who attended this preview that the need for advocates within the long term care system is as great as ever. Many substate Ombudsman Programs, however, cannot place ombudsmen within adult homes because of inadequate

funding. On the other hand, some Programs only serve adult homes, leaving the nursing home patients unserved because of the same funding constraints. Choices must be made; how to best serve the greatest number of our frail elderly citizens with the limited resources available to us.

With the reauthorization of the Older Americans Act in 1987 and the separate authorization for appropriations for the Long Term Care Ombudsman Program, we substate Directors felt hopeful that finally adequate funding would be coming to the states and to local programs for administering the only Program within the Older Americans Act specifically targeted to meet the needs of long term care facility residents. That hope was quickly dashed when it was learned the Ombudsman Program was subject to the "trigger" mechanism, thus relegating it to "second-class citizen" status! The only way for the Ombudsman Program to realize its appropriations under this separate authorization, is for the total appropriations for programs in effect in Fiscal Year 1987 to be increased by 5% over the previous year. We all know that hasn't happened; in fact there haven't been any increases. So here we are: a needed Program with a record of success; a Program able to integrate highly trained and skilled volunteers into a complaint resolution process that can and does involve providers, public agencies, social agencies, regulatory agencies, etc.; and a Program that often times is the only link a long term care consumer has with the "outside." At least the authors of the 1987 Older Americans Act reauthorization saw fit to mandate that states implement the Ombudsman Program regardless of the appropriations level. The guidance states were given was that they were to spend, at a minimum, the same amount from Federal funds as what was spent on the Program in 1987. What this means is even without the "trigger," the Ombudsman Program has to be funded at the minimum from funds allocated under the general supportive services category. At least there's some funding, but it is becoming less and less adequate as the need for advocacy for our most vulnerable citizens becomes greater and greater.

Our rapidly aging population, particularly among the old old, makes long term care one of the most crucial issues for Congressional concern. As we move into the 1990's and Congress concentrates its efforts on the financing of this care, we cannot forget the people themselves. They are our mothers and fathers, our grandmothers and grandfathers. We must insist on quality of care and quality of life; and we must continue to provide them with an avenue and a mechanism for their voices to be heard. Our legislators gave them that mechanism thirteen years ago; let's not take it away or weaken it. There is nothing waiting in the wings to replace it.

THANK YOU

Mr. DOWNEY. Thank you, Ms. Boyd.
Ms. Nemeroff.

STATEMENT OF THELMA NEMEROFF

Ms. NEMEROFF. Good morning. I want to thank Congresswoman Slaughter for the opportunity to address the need for funding elder abuse prevention programs.

While we are appreciative that elder abuse prevention has its own separate authorization under the Older Americans Act, it does not go far enough, since it relies on the trigger appropriations mechanism. Our local program will be critically short of money beginning January 1, 1990.

The current national estimate of elder abuse is set at approximately 4 percent of the population over age 60. This means that there is in excess of 5,000 elderly people in the Greater Rochester area being neglected, financially exploited or abused physically, verbally or psychologically. Statistics further conjecture that only one out of eight victims of abuse become known to the community. This means that seven out of eight elderly who are mistreated are invisible and are not receiving any help. How do we reach these people?

I believe New York State is mounting a major media blitz to inform the public about elder abuse and the danger signs about which you should be alert. I applaud this new action and anticipate that an informed public will bring new cases of elder abuse to our attention. But my question is, will there be adequate resources in the community to extend help to clients and families in crisis? Who will take care of these new cases brought to our attention of elder abuse?

The resources we need to do battle against elder abuse are competent, caring staff people; nursing home beds when necessary; good reliable aide service; respite care; support groups; and transportation for clients. I want to address these—the current status of these resources now.

Access to nursing home beds. At the present time, we cannot—without great difficulty—access nursing home beds for Medicaid clients on an emergency basis. The waiting period is usually 1 to 2 years. If the Medicaid client has Alzheimer's disease or other dementia, the job is even more difficult.

Recently, we had a client afflicted with Alzheimer's disease who was living with her daughter and her daughter's family. Unfortunately, the 7-year-old grandson and grandma were not getting along. He would do something to irritate her, and she responded by slapping him. It escalated to the point that his school work was being affected and he was being seen regularly by a therapist. Our client's daughter desperately sought placement in a nursing home. As she poignantly put it, "If I have to choose between my mother and my 7-year-old son who has his whole life in front of him, I have to choose my son."

The problem was, we could not get our elderly client into a nursing home, even after recommendations from a geriatric clinic, the child's therapist and many others. Finally, at a particularly tense time when the daughter was at her breaking point and seriously

considering abandoning her sick, confused mother, we were able to secure placement. We breathed a sigh of relief, but not for long because the very next day, another emergency placement was needed for a new client.

Aide service. Families who are under great stress or who are abusive need good reliable aide service to support them in caring for an impaired older person. Unfortunately, especially if the client is on Medicaid, aide service may not be either good or reliable. Medicaid does not pay a high enough rate to attract well-trained, reliable aides. Many of the caregivers we see who are in trouble are elderly themselves. It is difficult taking care of a wheelchair bound incontinent wife when you are 89 years old yourself and have high blood pressure. This couple is thrown into crisis each time the aide fails to visit. He simply cannot care for her adequately at all. It often takes staff intervention and advocacy to make the system work.

Respite care. Respite care, particularly for elder abuse clients, can make a difference. Families who receive respite from our staff get specially trained and supervised people. They not only offer leisure time for the caregiver, but also serve as role models for interaction with the disabled client. They have made a difference for families. However, our \$21,000 grant for respite ends as of September 30 this year. What will happen to these families who are at risk for neglect and abuse when we can no longer serve them?

Support groups and transportation. Support groups provide an opportunity for people to share their concerns, practical solutions, and frustrations. However, without transportation and respite care available, some of the most isolated and needy caregivers cannot attend. Our project provides this service currently. Who will provide it after our State funding ends in December 1990? Will the County of Monroe, under serious budget constraints themselves, be able to meet this very serious need?

Competent caring staff. Elder abuse prevention begins and ends with skilled caring staff people. This is a necessity when accessing services for clients at risk and working with families who are dysfunctional or in crisis. Older people who are being exploited for their money or for the homes they own need staff people who understand them and help them through our much too complicated systems.

Funding for elder abuse prevention is essential for all the reasons mentioned above. It is not enough to have the public alerted to the signs of elder abuse or to institute mandatory reporting. Once abuse is uncovered, we must be prepared to act in a responsible way with the resources necessary to provide the best interventions. Without resources, we are as helpless as are the victims we are trying to serve. Thank you very much.

Mr. DOWNEY. Thank you, Ms. Nemeroff, Ms. Boyd. Louise, do you have any questions?

Ms. SLAUGHTER. I do not have any questions, but I certainly thank you for that testimony. Do we have a copy of yours? I do not have it.

Ms. NEMEROFF. Yes, I just gave it.

Ms. SLAUGHTER. All right. Good. I want to be sure to have that.

Mr. DOWNEY. Thank you both very much.

Ms. NEMEROFF. Thank you.

Ms. BOYD. Thank you.

Mr. DOWNEY. We will continue with the provider perspective. Connie Boyd, Director, Genesee County Office for the Aging; Marguerite Nickel, Community Health Nurse, Monroe County Health Department, Monroe Community Hospital, Alzheimer's Family Outreach Program. Is Ms. Nickel here? And Teresa Galbier, Director of Developmentally Disabled Elderly Program, Regional Council on Aging. Ms. Boyd, if you would start.

STATEMENT OF CONNIE BOYD

Ms. BOYD. I would like to address the provision of services to elderly in a rural county, as I reside in Genesee County, which is sandwiched between Erie and Monroe. We are a rural county. Our elderly population is at approximately 11,000, which is 18 percent of our total county population. And over the past few years, we have noted more rapid growth in those 85 and over. Again, with the growing population, we have to look at maintaining services at least at the level that they are, if not expanding them to meet needs.

Again, being rural, we have a lot of constraints that may not be experienced in an urban county. We do not even have adult social daycare in existence in our county. We also do not have a long term care single point of entry in our county. So again, it is primarily our job to piecemeal together services as best we can as they exist and meet needs.

A number of the needs that we address are through our Aging Services Unit, and that exists within our Office for the Aging and has a full-time staff person, five part-time workers and currently two interns providing service to elderly in our county. I would like to just address some of the services that they provide and some of the limitations that we have had.

One is outreach. Again, that is just one of many duties that have to be performed by these workers. And as a rural county, we have added burdens of limited transportation and very limited media channels. Because of that, getting the word out basically means getting out the door and in your car and getting right into a rural elderly person's home and conducting a home visit to assess needs and provide service. Again, when you have a limited staff and you have elderly scattered throughout the county not really located in one central urban location, that means a lot of travel time and just time to locate those people. So again, our outreach service can be extremely limited, and we are just not reaching those people that are most in need.

Health insurance counseling, which has been mentioned before, again, we see as a vital need within our county. Currently, our Aging Services Unit has the two part-time workers, that one of their duties is doing this health care counseling. Again, deciphering insurance policies and the story of the forms coming in the paper bag is not new to us. People will save and save forms until they are so bewildered that they just do not know where to turn, and luckily, they find us. But again, with limited outreach, we sometimes cannot even get out the word that we have this valuable

service available. We are looking to supplement our paid staff through volunteers, and we do have 17 volunteers that are ready to undergo training to become health insurance counselors. But again, that is a sizable time commitment on their part and also the time that it is going to take for them to remain updated on insurance policies and procedures. I hope that we can depend on them, but again, that may really limit the service we can provide.

Ombudsman has also been mentioned. We basically had a program that was nonexistent or had faded. This year, our one full-time worker and one part-time worker did attempt training to be certified again, had to go into Erie County because we do not have training available within our county. So basically, that provides us with one worker to go into one facility. We have five facilities that are in need of ombudsmen. So again, we are not meeting needs that exist.

In general, transportation, I have mentioned before, and it is just a vital need in a rural county. But, we have very limited public transportation. And we basically, through our office, provide some direct transportation, but we focus on medical needs. We have a handy van that provides for wheelchair bound seniors. We have a bank of volunteers that provide medical transport to Erie and Monroe County when seniors need specialized health care and treatment. But, we do not even address other transportation needs of seniors. We just feel we have to set a priority to meet those that are most vital.

I urge you to try to look toward securing more funding for us with the reauthorization of the Older Americans Act. Again, I feel so strongly as a rural county, seniors cannot look many places for services, except to Office for the Aging. And in a rural county that does not have some of the services that urban counties take for granted, I really feel for them if we cannot provide the service. Where are they going to turn? Thank you.

[The prepared statement of Ms. Boyd follows:]

SELECT COMMITTEE ON AGING

FIELD HEARING TESTIMONY

PRESENTED BY: CONNIE BOYD, DIRECTOR
GENESEE COUNTY OFFICE FOR THE AGING

I would like to address the provision of services to elderly in Genesee County through Genesee County Office for the Aging.

Genesee County is a rural county located between Monroe and Erie counties in Western New York. 1980 census data projects a 1990 population of persons 60 years of age and older of 11,115. This is 18% of total county population. Our most rapid growth is in the 86+ years group, which is 8.6% of the total population 60 years and older. Those 75 years and older account for approximately one third of the Senior population.

Our county's Seniors have benefited from the Older Americans Act. It has provided the financial means to address a variety of needs of our elderly residents. The projected growth of our senior population in the 1990's points to the need for continued services and the funding necessary to provide those services.

A number of services we provide under Title III are delivered through our Aging Services department. Outreach, Health Insurance Counseling and the Ombudsman program are just a few of the areas with which our unit deals. Let me address the problems encountered with each.

OUTREACH

The rural nature of our county places an added burden on our outreach activities. Genesee County Office for the Aging is expanding outreach efforts so that needs of seniors can be addressed, eligibility for support through SSI or Medicaid can be explored and so on. However, the rural constraints, such as limited media channels and public transportation impede "getting the word out" and getting seniors to our offices. Therefore, our services staff must reach seniors through home visits. As our services staff consists of one full-time and five part-time people of which outreach is just one of their many duties, outreach is limited. Travel time necessary to reach seniors scattered throughout the county further limits the numbers we can reach.

HEALTH INSURANCE COUNSELING AND EDUCATION

One component of the Older Americans Act emphasizes provision of health education and promotion. Assistance with interpreting Medicare and Medigap policies is an integral part of our service. Two of our part-time workers provide this high demand service. Limited human resources, and limited financial support do not allow us to expand to adequately meet needs. Volunteer training is scheduled to help alleviate the workload, however, constantly changing insurance policies and procedures may limit the effective use of volunteers. Our limited staffing also reduces our ability to extend the service to villages and towns which surround the city where our Office for the Aging office is located.

OMBUDSMAN PROGRAM

The Ombudsman program is also hampered by funding and staffing limitations. The substantial training required further impedes expansion of the program. We are fortunate to have two people trained in our county: our Aging Services Specialist oversees the program and one trained volunteer will soon be placed with a local nursing home facility. However, this still leaves four nursing home facilities without an Ombudsman. Limited funding places a great deal of weight on volunteers to staff the program. This requires a considerable time commitment as well as travel expense, as training is not available in our county.

Other seniors needs are addressed outside our service office, such as transportation, home care for frail elderly and health education and promotion.

Transportation has been a long standing problem for our rural county. The limited public transportation has necessitated direct transport service through our office. We provide medical transportation through volunteers and with a handi-van. The van sets priority on serving handicapped, wheelchair bound seniors and only transports within the county. Volunteer drivers focus on out-of-county transports. We are unable to accommodate all seniors in need of medical transportation and do not at all address any transportation need beyond medical.

Despite state and local funding, the need continues to be great for in-home care for the elderly. It is paramount that we continue to provide the care that embodies the very intent of the Older Americans Act: to enable elderly to maintain dignity and self-sufficiency.

As a former administrator of a health care facility, I am concerned with the alarming rates of cancer in Western New York. These rates dramatically increase for those 50 and over. Health education, prevention and early treatment are vital. However, funding is again necessary to expand our health education component.

I urge that the reauthorization of the Older Americans Act brings with it funding to meet the many identified needs of Seniors.

As a service provider in a county which is without many services taken for granted in a more urban environment, such as a single point of entry in long term care or social adult day care, we carry the added weight of trying to piecemeal services for needy elderly. Without the Older Americans Act, where would they turn?

Mr. DOWNEY. Thank you, Ms. Boyd. Ms. Nickel.

STATEMENT OF MARGUERITE NICKEL

Ms. NICKEL. I have been a Community Health Nurse with the Monroe County Health Department for 5 years and with the Alzheimer's Family Outreach Program for 3 years. I am also a co-facilitator of an Alzheimer's support group in Brockport, New York. Through that time, I have seen scores of elderly caregivers, and the one fact that has remained—become crystal clear to me is that nursing home placement is nearly always considered a last resort. The caregivers that I know love the people that they are caring for, often a mate of 50 years or more. They earnestly desire to keep them at home, but they are tired.

I cannot even recall the number of faces that I have seen over the last few years, but I can recall vividly the fatigue on each one of those faces. They are exhausted. Elderly caregivers, whether parents, whether children caring for parents or spouses are exhausted mentally, physically and emotionally. And all too frequently, a placement is necessary because of that exhaustion before either the caregiver or the patient is ready to be placed. And the depression and guilt that that placement causes is greater than the exhaustion it relieves, and it takes a nursing home bed away from someone who really, really needs it at that point.

We have all had periods in our life when we have been tired. When we have a new baby or when we work nights or evenings. But, when you have a baby, that baby is going to grow up and you are happy to have it. And if you are a night worker and you do not get enough sleep, there is a weekend or a paycheck right around the corner. But if you are an elderly caregiver, there is no weekend or paycheck in your future. Elderly caregivers see no future.

When exhaustion becomes a way of life, your nerves are frayed, tempers flare and coping with the smallest task becomes impossible. How then, can we expect our elderly caregivers to cope with a husband who is up at all hours of the night or day—a husband who cannot be left unattended for one moment? It is an impossible thing.

What can be done to help caregivers? Respite—respite in all of its forms is by far the greatest unmet need that our Alzheimer outreach team has encountered. Families used to be able to give this respite. We lived under the same roof with our parents and grandparents until they died. But the last half of the 20th century has changed all that, and we live often miles—States—away from those that we love. And caregiving, too often, has become a solitary task. And yet, caregivers cannot live without respite. They need to be able to get a full night's sleep at least once or twice a week. They must be given the opportunity to see a new grandchild or attend a family wedding. They cannot lose hope that there is a future for them because that is what is taken away by unrelieved caregiving—hope. Hope that it will get better even for a few hours or a few days.

If funds were available, what I would like to see are senior centers renovated and constructed in a way that provides some respite for elderly caregivers. Even so much as day and night care, as well

as weekend care, so that those caregivers would know that at least on Wednesday and Friday, they could sleep through the night and be able to wake up refreshed to face another long endless day. Programs directed toward the memory impaired during the day would allow a caregiver to be able to be with their peers over the lunch hour and afternoon. And knowing that someone is taking care of their spouse.

In my support group, I have a lady who lives within walking distance of a wonderful program daycare—day center—senior center, but she cannot go because there would be nothing there for her husband, who sees her as his anchor. If there were a social daycare program at that senior center, she could spend the time with her friends. She could get some relief knowing that her husband could be in another room also being taken care of.

A caregiver needs respite so much and yet, there are other seniors that are robust—the young old—those in their mid to late 60's who also, while retired, want to feel useful. If training and education sessions could be given to teach those more robust seniors how to care for the frail and memory impaired, they could then provide respite for as much as a weekend to the seniors in their area.

EISEP training for personal care aides could be given at senior centers in outlying areas because I know a lot of seniors who like to do some respite or would be a good personal care aide. But because the training is often done in the middle of the city and not in Hamilton or Hilton, it is perceived as unavailable. If EISEP training could be done in senior centers, it would not only provide more people to give that care, but it would also eliminate one of the greatest barriers that we have, and that is transportation.

We are living longer today than we ever have before, and there is a pretty good chance that ever one of us in this room are either going to be frail caregivers or are going to be the people to whom that care is given. And respite can no longer be considered a luxury available to an elite few, but rather, a necessity that all have to have. Thank you.

[The prepared statement of Ms. Nickel follows:]

Testimony presented by Marguerite Nickel
 Field Hearing Witness
 June 11, 1990

Congresswoman Slaughter, Congressman Downey, Members of the Committee, Ladies and Gentlemen. Thank you for the opportunity to address an issue as vital to all of us as Support for Elderly Caregivers.

I have been a Community Health Nurse (CHN) with the Monroe County Health Dept. for 5 years and in that capacity have been the CHN with the Monroe Community Hospital Alzheimer Family Outreach Program since it began serving families in May, 1987. After three years of meeting with hundreds of elderly caregivers, one fact has become clear: Nursing Home Placement is nearly always considered the last resort. The caregivers I know love those they are caring for, often a mate of half a century. They took their Marriage Vows seriously and meant it when they said "In sickness and in health." These caregivers earnestly desire to keep their loved one at home and the idea of Nursing Home Placement causes them great distress. BUT THEY ARE TIRED.

I cannot recall the number of faces I have searched while hearing what a typical 24 hours is like for a caregiver, but I remember the fatigue on each of those faces. Elderly caregivers, whether spouses or children caring for a parent, are exhausted mentally, emotionally and physically. Because of that exhaustion, placement in a facility often becomes a necessity before either the caregiver or the patient is ready. All too frequently a placement of this nature causes caregiver depression and guilt greater than the exhaustion it relieves. It also makes one more bed unavailable to a client whose needs may be even greater.

We have all had periods in our lives when sleep has been scarce. Those in this room who are parents remember when days and nights ran together in a bleary haze as we cared for a newborn. However, we knew that our child would grow and eventually we would again sleep through the night. Plus we were younger and the gift of that infant more than made up for the fatigue. Night workers often experience sleep deprivation, but a weekend, and a paycheck, are just around the corner. An elderly caregiver sees no weekend or paycheck in their future. They see no future.

When exhaustion is a way of life, nerves are frayed, tempers flare, and coping with the simplest task becomes overwhelming. How then can one cope with a memory impaired husband who requires constant assistance and observation? A husband who is up at all hours of the night and cannot be safely left on his own? Sleep for such a caregiver is a hit and miss activity which is all too often missed.

I recently met with a gentleman whose wife gets up at night and, if he doesn't hear her, takes all of the food from the freezer and refrigerator. He awakens to an open, empty refrigerator and defrosting food about the counter. Does he love his wife? Certainly. Does he want to continue caring for her? With all of his heart. Will he be able to keep her at home? Not without sleep.

Another caregiver locks herself in the bedroom at night and allows her memory impaired spouse to roam the house aimlessly. Is she afraid he may harm himself or do other damage? Of course she is. She is simply too exhausted to do otherwise.

What can be done to assist such caregivers? Respite in all of its forms is by far the greatest unmet need that our team encounters. Families used to be able to offer respite and assistance with caregiving. We often lived under the same roof with our parents and grandparents until they died. The last half of the Twentieth Century has changed that however. My own parents live in Ohio and my Inlaws in Wisconsin. We are a mobile society and we often live far away from those we love. Caregiving is, for many, a solitary task. And yet caregivers cannot survive without Respite. They need to be able to get a full night's sleep at least 2 or 3 times a week. They must be given the opportunity too see a new grandchild or attend a family wedding. They cannot lose hope that there is a future for them. For that is what is taken away by unrelieved caregiving--HOPE. Hope that at some time it will be better, even for a few hours or a few days.

Currently in Monroe County there are 3 Respite beds available for patients whose needs are greater than those that could be met at an Adult Home level. They can be scheduled for no less than 7 days at a time and range in price from \$138 to \$143 a day. Medicaid will cover the cost of these beds, but other forms of health insurance will not. Unless one is very wealthy or at Medicaid level the cost can be prohibitive. It hardly matters though, because the beds are booked until at least the end of 1990. One of the beds is "spoken for" until March, 1991.

If funds were available Senior Centers could be constructed and renovated to provide Respite services for elderly caregivers. Day and night care, as well as weekend care, could be available to offer relief and allow a caregiver to sleep, at peace and undisturbed, a few nights a week. Programs directed toward the memory impaired during the day would allow a caregiver to spend the lunch hour and afternoon with peers while assured that care was being given to the spouse. Centers must be built to be especially diversified in rural areas where no other services will be available other than the ones it provides. A caregiver should not be penalized for living in Hamlin and not Rochester. Centers

could, in part, be staffed by Seniors who, while retired, feel the need to be productive and involved. Training and education sessions could be given to teach more robust Seniors how to care for the frail and memory impaired. These Seniors could then provide Respite for as much as a weekend to a stressed caregiver. Many of the retired persons I know between 65 and 75 would enjoy working as a Home Health Aide or Personal Care Aid for a few hours a week. They have the time and are certainly physically able. Classes however, are usually taught in the city and thus not perceived as readily available. Why not teach such classes at a rural Senior Center, and then employ the "pupils" as EISEP aides in the community in which they live. By doing this, one of the greatest frustrations of providing care--transportation--could be overcome.

If funds were available, EISEP could provide Home Health Aides as well as Personal Care Aides. Care could be available for a full two days once or twice a month instead of a few hours once or twice a week. Additional funds would enable programs to be available which provide case management to caregivers. Caregivers are often too tired and too overwhelmed to call a doctor and ask for much needed medication to calm their spouse. They have more than they can handle just making it through the day. A case manager can accomplish more in an hour than an overwhelmed caregiver can in a week.

We are living longer today than ever before. For the first time in history we have more living parents than children; more population over 65 than in their teens. The chances are great that we will all either become caregivers or those to whom the care is given. Respite for caregivers is not a luxury available to an elite few, but rather a necessity for all.

Mr. DOWNEY. Thank you, Ms. Nickel. Ms. Galbier.

STATEMENT OF TERESA A. GALBIER

Ms. GALBIER. Good morning, Congresswoman Slaughter and Congressman Downey. I would like to thank you for the opportunity to speak here this morning on older adults with developmental disabilities.

National trends show that the life expectancy of persons with development disabilities is increasing. This means that special programs to address their unique needs must be developed by agencies serving the aging population. We feel fortunate at the Regional Council on Aging to have a model program which has successfully met the needs of 31 older adults with developmental disabilities in the past 2½ years by providing comprehensive case management services so that they can successfully integrate into the existing senior services network with minimal supervision.

Current statistics show that there are at least 12,700 older persons with developmental disabilities age 60 and up in New York State, with at least four times as many estimated to be unknown to the developmental disability system. There are an additional 7,200 who are age 45-59 in New York State's developmental disabilities registry alone.

Older persons with developmental disabilities who are generally in the lower level income ranges suffer from the lack of social services and day care programs. Because of the trigger mechanism in the Older Americans Act, there is stiff resistance to increasing government spending on age-based social services. The older population with developmental disabilities is a segment of the elderly population facing the greatest need and receiving little or no targeted assistance under the Older Americans Act. Also, in-home support and respite services for families are necessary to avoid the costly alternative of institutionalization.

The provisions of the Older Americans Act of 1965, Public Law 89-73, as amended, call for each State unit on aging to have a State plan on aging in place. The plan must address how the area agency will ensure, among other things, that support services associated with access to services, for example, transportation, outreach, information and referral, are available, and in-home services such as homemaker and home health aide are provided. The act enables States to provide for a range of services, including in-home support, transportation and nutrition, as well as serve as an ombudsman and provide for centers where services for older persons can be co-located and more effectively coordinated.

Eligibility for services is generally limited to persons age 60 and over. The Older Americans Act must recognize persons with Down's Syndrome as aging at a much faster rate than the normal population. A working definition of the older developmentally disabled population must be developed by the act. Special provisions must be made to include persons with premature aging in the definition of the older or aging population with developmental disabilities. There is evidence that persons with mental retardation begin to decline in behavioral capacities during their 50's, incidence and onset of Alzheimer's disease is shown to occur earlier among per-

sons with Down's Syndrome and persons with mental retardation have a shorter life span when compared to the general population.

I would like to tell you a little case study of an individual that we presently work with. I will call her Jenny, but it is not her real name. I am going to change the name. Jenny has a diagnosis of severe mental retardation. She has been a resident of a local adult care home since May of 1984. She was placed by her cousin by marriage, Maryanne, after her mother passed away. Jenny resided with her parents all of her life. All other family members had severed ties with Jenny years before. Maryanne had been named in Jenny's mother's will as executor of the estate and guardian. The will had never been probated; therefore, Maryanne was not, in fact, legal guardian of Jenny, though she did claim to be.

After several years of residence in the adult care home, Jenny's trust fund was depleted, except for a burial account. Jenny is now on Supplemental Security Income, which covers her room and board and other expenses. Maryanne claimed to have maintained Jenny's personal monies in the estate account. Each time an adult home staff member, Virginia, the Activities Director, requested money for Jenny's personal care needs, Maryanne refused to send it. She claimed that Jenny's needs were being met. Also, Jenny was complaining of a toothache and needed dental work. Maryanne claimed that she was just saying these things for attention seeking behavior. Maryanne refused to schedule an appointment with Jenny's dentist. During this time, Maryanne had led everyone involved to believe that she was Jenny's legal guardian; therefore, she would be the sole decision-maker for Jenny. No one investigated the possibility that she was not, in fact, the legal guardian. She even led the Social Security Administration to believe this and the adult home and everyone else involved.

Virginia contacted the Regional Council on Aging's Advocacy Department for assistance. The Developmentally Disabled Elderly Program Director, me, had recently been certified as a Long Term Care Ombudsman through the Advocacy Department. The Advocacy Department Director assigned the Developmentally Disabled Program Director to the case since Jenny did have mental retardation and she felt, with her expertise, she would be able to handle this case. In her investigations, the Developmentally Disabled Elderly Program Director discovered that Maryanne, Number 1, was not Jenny's legal guardian; Number 2, had been neglecting Jenny's needs for several months; Number 3, was denying Jenny her personal allowance; and Number 4, was not placing the personal monies in the estate account.

After several months of advocacy, legal counseling, information referral and brokering of services, also case management and crisis intervention, Jenny is now participating in a local senior citizen center 3 days per week, with the assistance of a senior companion who was trained by our local Monroe Developmental Center's Senior Companion Program and is subsidized by the Senior Community Services Employment Program, the Title V program, here at the Regional Council on Aging. She is also receiving much-needed dental and medical care and has for her legal guardian Virginia, the adult home Activities Director.

I would like to make three recommendations for the 1991 reauthorization of the Older Americans Act.

Number 1, the Older Americans Act must recognize special populations such as those with Down's Syndrome and mental retardation as aging faster than the normal population. So that entitlement to the Older Americans Act for this population is at least at age 55.

Number 2, integration of older adults with developmental disabilities into existing senior services must be recognized as an integral part of the continuum of services for the older population. Adequate funding must be made available to provide training and workshops to staff of Older Americans Act programs to sensitize and educate them to the needs of the older adults with developmental disabilities.

And Number 3, adequate funding must flow so that additional staffing and support services can be provided for integration of older adults with developmental disabilities to take place. In a cooperative program such as ours, this can amount to as little as \$4,000 per senior center per year. Thank you.

Mr. DOWNEY. Thank you, Ms. Galbier.

Ms. SLAUGHTER. \$4,000 a center—not a person?

Ms. GALBIER. No, the cost per person is quite minimal because you are utilizing all of the existing services in the community and you are not providing new programming. So that way, you bring the cost way down.

Mr. DOWNEY. Let me just say quickly both to Ms. Boyd, that we appreciate some of the needs that you have in rural communities, and we want to account for that in the future. And Ms. Nickel, your testimony has been driven home many times and in other parts of the country that this respite care is absolutely essential. It saves money and saves lives, and we are very much aware of that.

Ms. SLAUGHTER. I think your idea of training other elderly retired persons as respite caregivers is good.

Mr. DOWNEY. It makes a lot of sense.

Ms. NICKEL. One of the things that rankles me—not rankles me—but I live in Hammondsport, which even though it is Monroe County, for all of the services that Monroe County has, it might as well be in the middle of I do not know where—Wayne County. So, just because caregivers live in Monroe County does not necessarily mean that have access to the services.

Mr. DOWNEY. Right. Thank you.

The subcommittee will next hear from Pat Campbell, who is an R.N., Nurse Consultant, Monroe County Office for the Aging; and Joanne Greene, who is a Counselor, Elder Counseling Program, Catholic Family Center.

STATEMENT OF PAT CAMPBELL

Ms. CAMPBELL. For the past 9 years, I have been one of two nurses under contract with the Monroe County Office for the Aging. Our primary responsibility is the planning of health programs for 16 Senior Centers. These programs can be categorized under basic health screenings, teaching, counseling and immunizations. For example, we conduct regular blood pressure screenings,

as well as group education sessions and are available for individual consultation regarding many health issues facing older adults. In addition, thanks to a strong network that has developed over the years, we are able to arrange for many community agencies to bring in health programs of interest to seniors. Finally, each fall, we join forces with the Monroe County Health Department to conduct flu vaccination clinics in the Senior Centers. We have had some programs that have been quite successful and of which we are very proud. In my written testimony, you will find details of three such programs that have won the National Association of Counties Award for Monroe County.

Along with the successes, though, we have had some frustrations. Among them was the loss of glaucoma screening previously done by the Association for the Blind and Visually Impaired of Rochester and diabetes screening by the American Diabetes Association. Fortunately, these services have since been provided through other organizations, but for a period of time, we experienced the loss of the important hands-on nature of these procedures, as well as the valuable teaching opportunities that surround each of these screenings. Although these screenings are being done now, some are funded by one-time grants, so the future of such programs is always questionable.

Therein lies the difficult aspect of planning health education programs. Not knowing what will become available to us or for how long it will continue. An example here is a Falls Prevention Program that was done for us by a University of Rochester student and supported by Blue Cross and Blue Shield of Rochester. We were able to provide this three-part teaching program to only three of our county's Senior Centers. Expansion of this program is desirable and a priority of this county's health educators. But, we have been unable to secure ongoing funding for such a program.

On the subject of exercise, the Center for Disease Control states that regular physical activity and exercise are critical elements in adult health promotion, and that we should be making greater efforts to promote exercise among the elderly.

Our ability to provide exercise programs, however, is quite limited. Two of the goals of exercise programs are to promote flexibility and to enhance cardiovascular performance. The goal of flexibility is addressed in a program funded by the Monroe County Office for the Aging and offered through the Arthritis Foundation that we heard about this morning entitled Motion Promotion. Along with county dollars, however, the program requires a participant fee. Although it is nominal, with close to 32 percent of our Senior Center population at or below poverty level, it is understandable that some who are most in need cannot consider a program with a fee. Consequently, many of the Senior Centers do not offer the program. Hence, the opportunity for our more frail or less mobile seniors to participate is lost.

The problem of co-payment, though, is not the only barrier to providing exercise programs. The reality is that even if interested seniors were willing to pay for such programs, the Office for the Aging does not have the funds to offer them.

For example, it is generally accepted that the best form of cardiovascular exercise is walking. However, there are a limited number

of organized walking programs that are targeted to older adults. The Heart Association does provide them in area malls and schools, but again, the less mobile seniors—those who probably need such programs the most—are not able to access them. Planned walking programs in existing Senior Centers would be a great benefit to this particular group. However, the current lack of funding just does not allow for staffing to meet this need.

It is always satisfying to learn of individuals for whom our programs have made a difference. And, we call these our success stories. Two of them are in my written testimony. I will tell you about one of them now.

We ran a Colorectal Cancer Screening Program, in association with Rochester General Hospital and Faye's Drug Stores. During this program, we handed out a total of 355 kits to interested people. Two hundred of these kits were returned to Rochester General Hospital for testing for occult or hidden blood, which is one of the signs of colorectal cancer. Of these 200, 10 tested positive for occult blood. At the time of the hospital's follow-up report, one of these 10 people had been diagnosed with cancer. Now, in the overall scope of things, one person does not sound like much. But I always keep in mind the fact that that one person could very well have been my father, in which case, that person becomes extremely important. Now, this is a person who, himself, had not been interested in taking a kit home, but his wife urged him to talk with the nurse who was distributing the kits. And she convinced him to take the kit home. So, each and every individual that we influence, in turn, influences others. So, the impact of educating each individual just becomes immeasurable.

We provide a great number of programs for our older adults and continually assist them in meeting many of their needs. And while it is gratifying to be a part of that process, it is also frustrating when we are faced with needs that cannot be met, or if met on a time-limited or selective basis. It is my experience that older Americans are interested in activities and information that promote better health. By covering a wide variety of topics, we can hit upon the needs of all groups represented in our Senior Centers; but sporadic offerings, such as what we typically have to work with, are a drawback to doing a complete, consistent job. Thank you.

[The prepared statement of Ms. Campbell follows:]

PREPARED STATEMENT OF PAT CAMPBELL

Chairman Downey, Congresswoman Slaughter, committee members: Thank you for inviting me to testify before you today, and for your interest in the subject of Health Promotion and Education. I have been involved in this field for the past nine years, and along the way have become more and more convinced both of the need to educate this population and of their interest, or desire to learn.

I am one of two nurses working under contract with the Office for the Aging. Our primary responsibility is the planning of health programs for 16 Senior Centers. These programs can be categorized under basic health screenings, teaching, counseling and immunizations. For example, we conduct regular blood pressure screenings, as well as group education sessions, and are available for individual consultation regarding many health issues facing older adults. In addition, thanks to a strong network that has developed over the years, we are able to arrange for many community agencies to bring in health programs of interest to Seniors. Finally, each Fall we join forces with the Monroe County Health Department to conduct flu vaccination clinics in the Senior Centers. We have had some programs that have been quite successful and of which we are very proud. One of these was a comprehensive Colorectal Cancer Screening program, done with the help of Pay's Drug Stores and Rochester General Hospital. This was one of three programs that won a National Association of Counties Award for Monroe County. Another award-winner is our "Reaching Out" program, done in conjunction with the Telephone Pioneers of America and the Hearing and Speech Center of Rochester. The intent of the Reaching Out program is to identify individuals with a hearing impairment and to help them explore the nature and extent of their problem. We have helped a number of Senior Citizens with the process of obtaining a hearing aid.

Our third and most recent program to win this award was our Tetanus Immunization Project. It was learned in the course of our work with older adults that a significant number of them (69%) were not adequately protected against Tetanus, a disease which is fatal to three out of four older adults who contract it. We conducted immunization sessions at 17 Centers, vaccinating more than 500 people. We are looking into the possibility of conducting a similar program again soon, based on the assumption that there will be people new to our program who have not had the benefit of education regarding the need for protection against Tetanus.

Along with the successes, we have had some frustrations. Among them was the loss of Glaucoma Screening previously done by the Association for the Blind and Visually Impaired of Rochester, and Diabetes Screening by the American Diabetes Association. Fortunately, these services have since been provided through other organizations, but for a period of time we experienced the loss of the important "hands-on" nature of these procedures as well as the valuable teaching opportunities, geared toward the participants,

that surround each of these screenings. Although these screenings are being done now, some are funded by one-time grants, so the future of such programs is always questionable.

Therein lies the difficult aspect of planning health education programs: not knowing what will become available to us, or for how long it will continue. An example here is a Falls Prevention Program done for us by a University of Rochester student, supported by Blue Cross and Blue Shield of Rochester. We were able to provide this three-part teaching program to only three of our County's 19 Senior Nutrition Centers. Expansion of this program is desirable AND a priority of this County's Health Educators. Ongoing funding for such a program, however, has eluded us.

On the subject of exercise, the Centers for Disease Control states that "regular physical activity and exercise are critical elements in adult health promotion" and that "greater efforts should be made to promote increased levels of exercise among the elderly to ensure the maintenance of vitality and an acceptable quality of life for older persons."¹ Our ability to provide exercise programs, however, is quite limited. Two of the goals of exercise programs are to promote flexibility and enhance cardiovascular performance. The goal of flexibility is addressed in a program funded by the Monroe County Office for the Aging and offered through the Arthritis Foundation entitled "Motion Promotion." Along with County dollars, however, the program requires a participant fee. Although nominal, with close to 32% of our Senior Center population at or below poverty level, it is understandable that some who are most in need cannot consider a program with a fee. Consequently, many of the Senior Centers do not offer the program. Hence, the opportunity for our more frail and/or less mobile Seniors to participate is lost.

The problem of co-payment, however, is not the only barrier to providing exercise programs. The reality is that even if interested seniors were willing to pay for such programs, the Office for the Aging does not have the funds to offer them.

It is generally accepted that the best form of cardiovascular exercise is walking. However, there are a limited number of organized walking programs targeted to older adults, due to the lack of available funds to provide them. The Heart Association provides them in area malls and schools, but again, the less mobile Seniors (those who probably need such a program the most) are not able to access them. Planned walking programs in existing Senior Centers would be a great benefit to this particular group. An added benefit of having them on site would be the ability to tailor them to the needs and abilities of the individual groups. However, the current lack of funding does not allow for staffing to meet this need.

It is always satisfying to learn of individuals for whom our programs have made a difference. These are our "success stories." Let me relate two of them to you now.

During the Colorectal Cancer Screening Program, we handed out a total of 355 kits to interested people. Two hundred of these kits were sent to Rochester General Hospital. Of these 200, 10 tested positive for occult (or hidden) blood, one of the signs of colorectal cancer. At the time of the hospital's follow-up report, one of these 10 people had been diagnosed with cancer. This was an individual who himself had not been interested in taking a test kit home but upon his wife's urging, spoke with the nurse offering the kits and was convinced to do so. Now, in the overall scope of things, one person does not sound like much, but I always keep in mind that one person could very well have been my father, in which case each person becomes extremely important. Each and every individual we influence in turn influences others, so the impact of educating each person becomes immeasurable.

Another example of the difference some of our health promotion programs have made comes from one of our diabetes screenings. We screened a woman with no history of diabetes who, we learned during the process, was having many of the symptoms of the disease but did not recognize them as such. She had a high blood sugar level at the time of the screening, so was referred to her physician for follow-up. Diabetes was diagnosed and treated, and this woman returned to us saying that she hadn't felt this well for quite some time.

We provide a great number of programs for our older adults and continually assist them in meeting many of their needs. While it is gratifying to be a part of that process, it is also frustrating when we are faced with needs that cannot be met, or, if met, on a time-limited or selective basis. It is my experience that older Americans ARE interested in information and activities that promote better health. Certainly, by covering a wide variety of topics we can hit upon the needs of all groups represented in our Senior Centers, but sporadic offerings such as what we typically have to work with are a drawback to doing a complete, consistent job.

Reference:

1. Surgeon General's Workshop on Health Promotion and Aging: Summary Recommendations of Physical Fitness and Exercise Working Group. JAMA 1989; 262:2507-2510

pf/wp

Ms. SLAUGHTER. Ms. Greene.

STATEMENT OF JOANNE GREENE

Ms. GREENE. My name is Joanne Greene. I am a Counselor at the Catholic Family Center. And I am here to talk about really two issues. One is the mental health needs of the older people. And to touch on some of the elder abuse which we have heard about today.

The Elder Counseling Program at Catholic Family Center provides counseling and emotional support to older adults in Monroe County. Our program and Project Reach at Rochester Rehab are the only programs that I know of which are specifically designed to meet the mental health needs of older adults in Monroe County. Well, you might be tempted to breathe a sigh of relief knowing that some action is being taken to address this need. But, I am here to explain to you that we are just scratching the surface of the problem. That we cannot possibly meet this need. That many older adults are sitting home alone, their wastebaskets filled with tear-soaked Kleenex.

And why? Well, let us start by looking at some of the normal stresses and challenges faced by the older adult. There is often the need to adjust to the loss of a career identity, financial loss, failing health, or perhaps the loss of a spouse. Maybe even the loss of one's independence. I spoke last week to a man who was being admitted to a nursing home. His wife died just 2 years ago, and he felt incapable of going through life without her. He said, "I realize now that this is the beginning of the end, and I am going to die." I saw a woman in her 60's who had cared for both her mother and two brothers until their death. I was doing caregiver counseling with her. Now that the brother is gone, she feels that the very core of her existence—that of being a caregiver, has died, too. She no longer knows who she is. For the first time in her entire life, she goes home to an empty house. And it terrifies her. She needs to talk about this.

And these are the simple cases. But it is not just learning to accept the death of a spouse, or adjusting to terminal illness, or dealing with loneliness or depression that older persons might face. There are often harder issues. Like the mother in her sixties whose daughter walks the streets to pay for her cocaine habit. Or the elderly couple whose alcoholic son steals what limited income they have. Or the older woman nearly beaten to death by her husband. And the many older persons still tormented by memories of childhood abuse. A woman in her nineties described to me how her mother and brother were shot to death during World War II. She did not really mourn for them then because she was too busy trying to survive herself. But now there is time for her to think and to cry. Unfortunately there is no one available to listen. No one who can really give her the time that she needs.

Let me share some facts with you. Last year our three counselors saw nearly 500 clients. A caseload at any one time might be 50 to 70 persons, most of whom are over 75 years of age and homebound. It does not take a mathematical genius to figure out that it would be impossible to see that many persons in their homes even as often as twice a month. In short, our small program cannot begin

to provide for our clients the amount of service that they really need and deserve. We would have to triple our staff to do so.

So what are their alternatives Older persons could see a psychiatrist if they could afford the 50 percent—and mind you, this is about \$100 a visit—that Medicare will not pay and if they could get to the office and if they were not afraid of the stigma of seeing a psychiatrist. But research has shown us that most older persons do better with a more personally supportive and less formal approach. We have learned that outreach produces better results, and that older persons appreciate being met halfway.

A handful of professional counselors cannot meet the mental health needs of our ever-growing elder population. And we cannot begin to address prevention of depression in the elderly, even though we are aware of exciting, innovative concepts to do just that. We simply do not have the staff and there is no funding for more. We feel strongly that the State and county budgets have accepted this burden for too long, that Federal dollars are needed to resolve this problem. Our program is funded by the Monroe County Office for the Aging, the United Way and by contributions from the clients. What that means is that the State of New York and Monroe County do their share. Our community does its share, as do the clients, and I submit to you that it is time for the Federal Government to do its share too.

Thank you.

Mr. DOWNEY. Well that was a fitting end to the morning session. We agree that the Federal Government should do its share.

Thank you, Ms. Campbell and thank you, Ms. Green.

The subcommittee will stand in recess for 1 hour.

[Whereupon, at 11:54 a.m., the subcommittee recessed, to reconvene at 1:14 p.m., the same day.]

AFTERNOON SESSION

Ms. SLAUGHTER. Good afternoon.

Kathy Lewis from the Monroe County Office for the Aging is going to show us a tape for a few minutes. So, Kathy—this is the exercise class we heard about this morning with Ms. French.

Ms. LEWIS. No, this is another one.

Ms. SLAUGHTER. Oh, is it? I am sorry.

Ms. LEWIS. This is a tape that was done with another instructor. This is a tape that was done to show the hearing, those present, what the class actually looks like in action.

[Whereupon, the videotape was shown.]

Ms. SLAUGHTER. The subcommittee will finish this morning's panel of the provider perspective by hearing from Marta Bermudez from St. Mary's Health Screening Program. If Marta will just come up front.

Thank you, Ms. Bermudez, we are ready for your testimony now.

STATEMENT OF MARTA BERMUDEZ

Ms. BERMUDEZ. I thank you for having me speak to you this morning—or afternoon rather. I have some brochures—can you just give them one?

I am representing the Community Screening and Treatment Program of St. Mary's Hospital but also I used to work, years ago, for West Side Health Services and this program that I coordinate is done in conjunction with West Side Health Services.

I would like to address the issue of prevention services, I feel strongly that prevention serves three things in the community; it saves lives, it improves the quality of life and it also saves dollars in the long run. I can bore you with lots of statistics, but I will not do that. You probably heard quite a few this morning about how the population is getting older and by the year 2000 there will be more of us over the age of 65, how in minority communities illnesses are more prevalent, there is more chronic disease. Whatever illness you want to name is higher in minority communities and so on and so forth. I have submitted a number of documents which have information from the vital statistics of New York State which shows all of that, and newspaper articles and so on and so forth. So that information is available. Also, the cost effectiveness of prevention programs is something that has been documented for years, so I do not feel like I want to go over that again.

What I would like to spend a little time with is explaining my program that I coordinate and also the Faith Community Health Awareness Program, which is a program on the corner of Genesee and Bronson. The screening program that I coordinate right now is funded by the primary care network and also by St. Mary's Hospital. We do screenings in the community, primarily targeting the southwest area of the city which has the highest incidence of all these chronic diseases. We also go all over the county to any place that will invite us and we try to target mainly the elderly at this point. We have screens at all of the Monroe County Senior Nutrition Sites for cholesterol screening, glaucoma, diabetes and blood pressure. One of the centers that we go to on a monthly basis—and I see some familiar faces—is the Montgomery Neighborhood Center and the waiting room of the Monroe County Department of Social Services and also the Faith Community Health Awareness Program.

This program has three aspects; one is the screening, and we feel it is very important to detect disease at an early stage because that is where you get the most cost. If you wait for the problem to progress to a place where it is an acute illness, then you have what could have been prevented with simple hypertension screening, can then become a dialysis concern. So that the cost of preventing an illness is much less than treating it at a later stage.

According to the statistics, heart disease, cancer and stroke are the three leading causes of death for people between 60 and 79 and also for the group 80 and over. There was a study that I saw in the paper that—a study of 45 States and the District of Columbia, where it said that 2 percent of State monies is spent on—is only spent on the nine diseases that cause half of the United States deaths. So I really believe that more money needs to be spent in programs like this where we can find the people who are suffering from these illnesses, where you can teach them ways in which you can prevent these diseases where they can change their lifestyle and make an impact on their health and also in the health of the community around them.

The second aspect of our program is health education and we stress weight control, because obesity is very high in our community, especially in the elderly community and minority community. Obesity alone is one of the biggest health risks and health factors that contributes to heart disease and stroke and diabetes and so forth.

Reduction of stress—I saw a program last night, "60 Minutes", I do not know how many saw it, but they were talking about the suicide rate among the elderly and it just turned my stomach. I have a father who is 79 and a mother who is 70 and I am watching these middle age sons and daughters sitting there not knowing that their parents were even considering this. And I am thinking the same way, I thought, "well, are they even thinking about these things." I think the level of stress for the elderly is high because of lack of funds, limited income, they are not as mobile as they used to be and just the thought of the loneliness and aloneness that they experience.

The Faith Community Health Awareness Center on Genesee Street is a program that was started through Federal and State monies back in the fall of 1982. And it was stopped because Federal monies were cut. A retired individual named Oza West continued the program on her own with her own monies and through volunteer help from the community. The majority of the people who run that program on a daily basis are elderly women who started coming there doing crafts and so forth and then they continued on and they help distribute clothing and food and so on.

One of the things that I have found in reading is that volunteering and doing volunteer work and having a sense that you are contributing to society reduces stress and it also helps the people around you. And I think, therefore, this particular group of ladies who work out of there and even the ladies here from Montgomery Center who I have come to know a little bit—I do not think that suicide crosses their mind too often because they are productive, they do things, they feel well, they are taught how to change their lifestyle and their habits and also they are taken out, they go on recreational trips and the skills that they have gained over the years, they can share with younger generations and with others in the community.

I keep going back and forth because my mind is like all over the place here, I am very nervous.

But to me, it is like these things are not disconnected. I think when you have any illness, even hypertension, diabetes or anything, and all you do is sit at home and brood about your social problems, your health problems and everything else and not get out of yourself into a program where you are stimulated and you are taught, then you feel worse, you feel worse about yourself and your illnesses do become worse in and of themselves.

For a good health promotion program to be effective, I think you have to have a few components; nutrition, information, physical fitness. A lot of our illnesses and immobility have to do because we do not use our bodies and we do not get out and move around and we do not reduce stress in that way and we do not reduce our weight in that way.

Nutrition, physical fitness and also primary care services—I think that in our program we have found a lot of elderly who say they have doctors but they do not visit their doctor too often, if at all.

Other factors such as smoking and learning how to do exams on yourself such as breast exams. A lot of our older people die of breast cancer and in the black community there is a very low survival rate with cancer. So it is very important that some of these things be found early.

The only other thing I would add at this point is that I feel that it is very important that the State put monies into these things. I think that although statistics, you know, you can play with them either way, but when you go out into the communities and you go to the senior centers and you go into the areas where seniors are and into the high rises where we do some of our screenings, I think there you see the truth and in those places you see people who oftentimes go hungry, they are immobile, they do not get around. There needs to be an outreach to them and I believe this is what this screening program does and this is what programs such as the Faith Community Health Awareness Center does, it reaches out to them and engages them in conversation and to a level of trust where they can then say okay, I will go to the doctor or I will check out this program, because sometimes you hear well there are so many programs and people do not make use of them—well maybe we should take a look at how those programs are run and are they really the programs that the people need or want.

I think, therefore, monies to be spent wisely—there is always “well, there is not enough money”—well there seems to be monies for things, you know, military and everything else that people want to make money for. But I think that we need to invest in our seniors. There are young girls who have babies that do not have anybody to care for their babies. For instance, at this health awareness center, we started a 4-H Club and the 4-H is run by the seniors. There are a lot of things that the older generation can teach the younger and there are things that they can do. And all these things together make up good health. It is not just going for your annual flu shot. There is a whole conglomeration of things that make up a person's feeling of good health.

I really do not have much more to say.

Ms. SLAUGHTER. That is excellent. And I think the point that you are making is that everybody feels better if they know that they are needed and they are a part of something. I think it is isolation that is such a critical problem.

Ms. BERMUDEZ. Yes.

Ms. SLAUGHTER. You mentioned that the people that you serve often will not go to their own doctor. One of the reasons that we are holding this hearing today is to highlight the need for increased funding of the Older Americans Act to fund health screening at senior centers, believing that if we can find these things early, as you pointed out, that a great deal of money as well as a lot of pain can be saved.

Ms. BERMUDEZ. Right.

Ms. SLAUGHTER. But people who will not go to their doctors, is that a transportation issue, do you think, or a financial matter? Why do you believe they will not go?

Ms. BERMUDEZ. I think it is a combination. For instance, I found a lady who had very high glaucoma and I asked her did she have an eye doctor and she said yes and I said well can you go and she said well it depends on whether my son can take me or whether this person can take me or not. Sometimes it is transportation. Other times, I think it is fear.

Ms. SLAUGHTER. Just need somebody to go along.

Ms. BERMUDEZ. Right, exactly, someone to coax them and say okay, let us go, I will go with you. Or sometimes they are afraid of results. And I think too, with some of the elderly, at least some of the ones that do not go, they feel like well, it is almost like they are waiting to die, and why not. I find that to be very sad because I have also found with some of the more positive seniors that I have met, they are not waiting to die. They cannot wait to get out there and live and enjoy life. And that is what life is until we actually die, we are here to live it to its fullest. I think it is very sad that you have that mentality, and that is where like the suicide thing comes in. We need to reach out to those people that just sit around and feel depressed because depression is real and for some people, they lose their spouse or whatever and then they lose their will to live or they feel they cannot make friends. But there needs to be a reaching out to them.

Ms. SLAUGHTER. You mentioned breast cancer too, which is something we have been very concerned about, 44,000 women die a year of breast cancer in this country.

Ms. BERMUDEZ. Yes.

Ms. SLAUGHTER. Do you do mammography or recommend it or make it possible for people to get it? I know lots of women do not go because of the expense.

Ms. BERMUDEZ. Right. I am glad you asked me that because we are right now in the process of developing two health fairs, one in the southwest and one on North Clinton. And that was an issue that was very strong because we are going to go out there from the van from Roswell Park in Buffalo and we are going to do exams right there in the van on the street. And what happens if the woman does have a lump or something and she needs follow-up. Well presently the only free service for mammography is at Strong and my understanding is that there is a waiting list so long because the people who are using it are from Penfield and Pittsford and people that have insurance who do not want to bother with their insurance, they just go and get a free mammogram, yet the people who really need the service, who should access this, do not.

We are looking now to possibly putting in for like research monies or different kinds of monies to see if we can do that, offer free mammograms or at a very minimal fee, to the elderly.

Ms. SLAUGHTER. That is one of the things that we are looking at too, is funding for mammograms under insurance, which would be very helpful.

I really thank you for coming today.

Our final witness is county legislator, Joseph Morelle, who is Assistant Majority Leader and been involved in aging issues for how

long, Mr. Morelle—3 years. Welcome, please have a seat here at the table.

**STATEMENT OF JOSEPH MORELLE, ASSISTANT MAJORITY
LEADER, MONROE COUNTY LEGISLATURE**

Mr. MORELLE. Good afternoon, Congresswoman.

Ms. SLAUGHTER. Good afternoon.

Mr. MORELLE. I have to apologize, most of my remarks will be extemporaneous. We had prepared testimony and unfortunately due to computer technology, we somehow lost it about half an hour ago, so we will submit it in writing.

Ms. SLAUGHTER. It is out there somewhere.

Mr. MORELLE. We have high-trained staff but they sometimes press the wrong button. So I apologize.

But I would like to thank you and other members of the Select Committee on Aging for giving the residents of Monroe County the opportunity to address you on the Older Americans Act. This hearing comes for me at a very opportune time because just last week I submitted, along with the Vice President of the County Legislature, Fred Amato, a package of legislation to the legislature entitled "The Senior Omnibus Referral", and this package, which contains 23 separate referrals was the result of over 2 years of research conducted by the Legislature Special Committee on the Elderly which I had the pleasure of serving as Chair.

The package we put together was an attempt to provide a comprehensive policy guide for the legislature and for the entire government of Monroe County to meet the needs of our dramatically expanding senior population. And the package covers such topics as health care, housing, transportation, recreation, emergency medical needs and many others.

The package contains seven pieces of legislation which deal directly and indirectly with assistance that the county senior citizens receive and need from the Federal Government and I wanted to just briefly review those resolutions with you here today, recognizing that some may have more to do with Federal Government assistance, some have less to do with Federal assistance and perhaps more with State assistance, but probably you more than anyone in this community understand the relationship between the Federal, State and county governments, having served at all three levels of government.

There are a number of different parts of the Older Americans Act that I am particularly concerned about. One is Title III(3), the support services in the Older Americans Act, which funds the provision of information and referral, counseling, transportation, legal, nursing home, ombudsman and other related social services necessary for the welfare of older residents. We also have in our package—we deal with sensitivity training which comes under I believe Title III(T) training and home support services, and we believe there should be some consideration given to the Medicaid rate for home health care with the provision that it be passed along to employees with which we have a serious shortage of home health care workers.

In our packet, what the county legislature refers to which constitutes referrals, which other levels of government may call legislation or bills, the first one that I wanted to just briefly talk about is 900631—and I will submit all these to the subcommittee. That particular referral deals with Medicaid recipients who qualify for nursing home care but are unable to secure placement in a nursing home due to lack of beds. My primary concern and my hope is that the Federal Government can work with New York State—I think there is some concern about the realistic numbers of nursing home beds that the State has allowed and whether or not the Federal Government can work with the State to increase the numbers, potentially the numbers of nursing home beds, to alleviate that shortage.

Our referral 0632 deals with home support. One of the major focuses of our committee was the issue of how to enable seniors to remain independent in their homes and to avoid or delay institutionalized care. In the final report, we note that the Federal cuts have limited funding for in-home services, shifting the burden to the localities. In some cases, institutionalization may rob a senior citizen of their freedom, their dignity, their self-esteem, particularly when it is not necessary for them to be there, and certainly takes away from their life savings and whatever assets that they may have. We also believe that in the long run increases taxes because of the tremendous burden, the Medicaid burden, for people who are institutionalized who may not need to be there. We have requested in our package that the Federal Government increase funding for home health care, which would allow eligible clients, after an ongoing assessment review, to receive care 5 days a week rather than 3 days a week in order to keep those individuals out of institutionalized care or at least to avoid it for as long as possible.

Referral 900633 deals with the continuing problem and availability of home health aides, which I referred to earlier, and we discussed in our committee the enactment perhaps of a minimum wage and benefit program for home health aides on the State level and we believe this is a critical issue in containing the cost and providing quality to keep people in their homes and we are urging that the State consider this problem and consider increasing the Medicaid rate for home health care with the provision that the increase be passed along to the workers. And we believe that it is important for the Federal Government to work with the various State governments to try to find ways of providing the dollars to meet that need, and that is funded, I believe under Title III(T). I would just urge continuation of support for sensitivity training. And we find during our hearings which we held in which we encouraged home health care providers to come talk to us, that in some measure there is perhaps a lack of sensitivity to the physical and mental health needs of senior citizens. And under Title III, there is support in the Federal Government, some funding for sensitivity training and I would just encourage the continuation of support for that particular program.

Again, talking about the home health professional shortage, we in the legislature are awaiting the county—asking for a study to be done on the size of the current and projected backlog for residents awaiting service, home health service, and again this is directly

tied in to the need for the greater number of people who enter this career field and try to keep them—prevent some of the high turnover in this profession. And it is my thought that perhaps this could be tied in some way to a career ladder or career advancement. I am not certain what the likelihood is or how desirable that is, but I think that is one way perhaps of approaching that problem.

We also addressed in our committee in Referral 900635, family respite. We believe that all levels of government, whether it is local, county, State or Federal Government, ought to really consider ways of providing funding and really naming as a high priority family respite. So many people have as their primary caregivers, families, and it is difficult for those families at times to have the necessary time away to be able to continue to provide that service. So we consider it a priority, we I hope will be looking for dollars both county dollars as well as private foundations, perhaps United Way and we hope to approach them. Certainly any additional dollars that could be provided by the State of New York or by the Federal Government to expand family respite we believe would be quite appropriate and in the long term would be very cost effective.

Finally, I would just comment on recreational programs for senior citizens which really in our view promote social and emotional adjustment, constructive use of leisure time, community involvement, and provide a great deal of physical well-being. As I understand it, Federal dollars in this area have been decreased in the past year and I would encourage the Federal Government and this subcommittee in its role with the Federal Government to try to provide some additional dollars locally, the emphasis for these recreational programs comes out of the senior centers run by and operated by the County of Monroe. And I would greatly encourage a renewed look at that particular funding item and encourage the development and continuation of recreation programs for senior citizens.

In conclusion, I would just like to say again how grateful I am to the members of your subcommittee for allowing our community to address these concerns. Our population, as it grows older, will demand new and different services that will deviate significantly from those demanded by previous generations. Currently every level of government; Federal, State and local, is strained by overwhelming demands for better services and devastating budget constraints. In order to adequately address the needs of our senior citizen population, we need to plan now for a system that is well financed and of the highest quality and we hope we are leading the way in this community and the Monroe County Legislature and I know you are doing all that you can at the Federal level and I encourage you to continue. I appreciate your efforts to make our senior citizens a happier, healthier future.

Ms. SLAUGHTER. Thank you. Our purpose here today is to hear testimony on the necessity for reauthorization of the Older Americans Act and to get the programs funded.

I think as Tom Downey put it this morning, an ounce of prevention and a pound of cure. What we are doing now is wasting millions of dollars when we could save millions more if we spent them correctly.

I wanted to bring one thing to mind. We had numbers of people testify this morning with excellent ideas on the home health care issue. And one of the concerns is that the aides are much easier to obtain in areas where there is good bus service. If you live in the outlying parts of this county or the rural counties, it is almost impossible to get anyone to come out. And I wonder if the county has addressed that in any way.

Mr. MORELLE. As a matter of fact, in one of the referrals that we submitted—there are actually a number of them that deal with transportation, but particularly as it relates directly to this issue, we have called upon the Genesee Region Transportation Authority as well as the county and the Rochester Transit Authority—as well as the Genesee Transportation Council, all of which deal with transportation issues, to investigate ways of increasing bus services from suburban locations and rural locations to other rural and suburban locations, to really try to increase those numbers and provide access. Most of those routes, as I understand it, currently go down through the core of the city and in some cases that may not be necessary or appropriate and we may be able to expand services without seriously expanding the funding required for it.

So we do understand that and it is something that I think needs to be done at the local level and we are trying to encourage whatever expansion we can, within the budget constraints that obviously everyone faces.

[The prepared statement and attachments of Mr. Morelle follows:]



Monroe County Legislature

JOSEPH D. MORELLE
LEGISLATOR - 16th DISTRICT
370 LAURELTON ROAD
ROCHESTER, NEW YORK 14609
RES. 716-288-7921
BUS. 716-428-2040

ASSISTANT MAJORITY
LEADER

COMMITTEES
Vice-Chairman:
Agenda/Charter
Planning & Economic
Development

**Testimony of Monroe County Legislator Joseph D. Morelle, Chair
Special Committee on the Elderly**

Monday, June 11, 1990

I would like to thank Congresswoman Louise Slaughter and the other members of the Select Committee on Aging for giving the residents of Monroe County the opportunity to address you on the Older Americans Act. This hearing comes, for me, at a very opportune time because just last week I submitted a package of legislation to the Monroe County Legislature entitled the Senior Omnibus Referral. This package, which contains 23 separate referrals, is the result of two years of research conducted by the Legislature's Special Committee on the Elderly, which I have had the pleasure of serving as chair.

The package was an attempt to provide a very comprehensive policy guide for the County of Monroe to meet the needs of our dramatically expanding senior population. The package covers such topics as health care, housing, transportation, recreation, emergency medical needs and many others.

The package contains seven pieces of legislation which deal directly and indirectly with assistance that Monroe County's senior citizens need from the federal government. I would like to briefly review these resolutions here with you today.

Ref #90-0631

Elderly Medicaid Recipients who qualify for Nursing Home Care

Title III-3 - Support Services of the OA Act funds the provision of info transportation, legal, nursing home ombudsman, and other related social services necessary for the welfare of older residents.

One of our greatest concerns are the elderly Medicaid recipients who are backed up in hospitals and may qualify for nursing home care. We have requested information from the Finger Lakes Health Systems Agency regarding a more realistic analysis of the actual Medicaid funded bed shortage. We feel the state needs to address their methods of analysis more realistically, as their statistics show a minimal need for beds, while locally the Fingerlakes Health Systems Agency shows a crisis.

R-90-632

Home Support - Home Health Care

One major focus of the Special Committee of the Elderly was the issue of how to enable seniors to remain independent in their own homes as long as possible. Federal cuts have limited funding for In-Home services (Title III-D), shifting the burden to localities. More alternatives to institutionalization need to be developed and funded. In many cases, institutionalization traps senior citizens, robs them of their freedom, as well as their dignity or self-esteem, strips from them and their spouses their life's savings, and in the long run increases everyone's taxes.

In this referral, we are urging the United States Government to increase funding for home health care, allowing ELIGIBLE clients after ongoing assessment review to receive care five days per week, rather than three days per week. This would keep those individuals out of institutional care.

R-90-0633

Home Support - Home Health Aides

The Home Health Aide profession is plagued with high turnover due to low wages. Funding under Title III-D. In-Home Support Services provides for light and heavy chore services, respite services and minor in-home modifications. Though Home Health Aides provide services for anyone eligible regardless of age, we know that the elderly are the fastest growing segment of this population. It is a fact of life that people are living longer and we cannot and should not expand our nursing homes SIMPLY BECAUSE there is not enough decent, affordable home care.

This referral requests that consideration be given to increasing the Medicaid rate for home health care with the provision that this increase be passed along to the home health aides by their employers.

R-90-0646

Sensitivity Training

Title III-T of the Older Americans Act funds the provision of specialized training and education to professionals, paraprofessionals and volunteers working in the field of aging. As such, Referral 646 addresses the need for Monroe County to develop an education program designed to train these individuals in order to sharpen their sensitivities to the physical and mental health needs of senior citizens. This funding is a necessary component to the support and well-being of seniors and I commend the federal government for continuing this funding for our use and hope that it will increase.

R-90-0647

Home Health Professionals Shortage

The Special Committee on the Elderly was alarmed by the shortage of home health professionals. Referral No. 647 requests updated information on the size and projected backlog for residents waiting service by Monroe County's Public Health Nurses under the Health Department's Home Health Agency. Though this funding is not directly channeled through the Older American's Act, federal monies have been drastically reduced by over \$1 million dollars. We hope to have information soon regarding the needs in Monroe County and at that time we will be happy to advise the Select Committee of our findings.

R-90-0650

Support of Recreational Programs for Seniors

Under the Older Americans Act, funding from the Federal Senior Center Recreation Program continues the State Recreation Program Services provided, with an emphasis on the Senior Centers located within Monroe County. Educational and recreational activities to persons over age 60 is an effort to promote social and emotional adjustment, constructive use of leisure time, community involvement, and physical well-being. In referral No. 650, we are requesting additional federal funding for the expansion of recreational programs for seniors.

R-90-0652

Long-Term Care for Seniors (CASA's)

Also included in this testimony for your review and comment is a referral on a Community Alternative Service Agency (CASA) model, which would enhance long-term care for seniors. Identifying those at risk of institutionalization and then planning to prevent it is a complex challenge involving Medicare and Medicaid limitations, the income levels of those at risk, which are all possible barriers to the provision of prevention. Monroe County began investigating this concept last year, but work has been postponed due to fiscal restraints. We feel CASA's are a worthwhile idea and would urge the federal government to consider funding for pursuit of this concept.

In conclusion, I would like to say again how grateful I am to the members of this committee for allowing this community the opportunity to address the concerns of the elderly.

Our population, as it grows older, will demand new and different services that will deviate significantly from those demanded by previous generations. Currently, every level of government . . . federal, state and local . . . is strained by overwhelming demands for better services and simultaneous devastating budget constraints. In order to adequately address the needs of our growing senior population, we must plan now for a system that is well financed and of the highest quality. I appreciate your efforts in making the future for our senior citizens a healthier, happier future.



Monroe County Legislature

900630

JOSEPH D. MORELLE
LEGISLATOR - 18th DISTRICT
370 LAURELTON ROAD
ROCHESTER, NEW YORK 14609
RES. 716-286-7921
BUS. 716-429-2040

ASSISTANT MAJORITY
LEADER

COMMITTEES
Vice-Chairman:
Agenda / Charter
Planning & Economic
Development

May 22, 1990

Monroe County Legislature
56 West Main Street
Rochester, New York 14614

Re: OMNIBUS ELDERLY REFERRAL

Honorable Legislators:

Monroe County reflects a growing national trend commonly referred to as the "Graying of America". Only twenty years ago, the number of people in our community over the age of 65 was 68,000; today that number is almost 90,000. From 1970 to 1990, during which the general population of Monroe County dropped 1.4%, the number of our residents over the age of 65 grew 38%. Assuming that Monroe County will continue to follow this national direction, we will see an even sharper increase in our senior population.

On a national level, census figures indicate the following:

- The number of people over the age of 65 grew from 20 million in 1970, or 9.8% of the population, to 31.7 million in 1990, or 13% of the total population.
- It is projected that by the year 2050, the number of people over 65 will increase to 67.4 million, 32% of our nation's population.
- Not only is the number of senior citizens increasing at a dramatic rate, but so is the number of "very old" or "frail elderly". The Census indicates that the number of people over the age of 90 will increase 236% to a total of 1.5 million by the year 2000.

The serious increase in the number of senior citizens in our society will have repercussions on our economy. Caring for our elderly, particularly in institutional settings, will cost a great deal. For example, the care for a nursing home resident in Monroe County is currently between \$38,000 and \$43,800 annually. Medicaid payments are projected to cost Monroe County taxpayers \$842 million dollars in 1990. In addition, there is a hidden but definite impact on our economy from the strain borne by 20% of working Americans who care for an older parent. Furthermore, it is a disturbing fact that the average Fortune 500 company now supports one retiree for every three of its active workers.

Our population, as it grows older, will demand new and different services that will deviate significantly from those demanded by previous generations. In critical areas, such as health care, transportation, housing, and recreation, our society will be presented with its greatest challenge in meeting the needs of our grandparents, our parents and, eventually, ourselves.

Currently, federal, state and local governments are severely strained by the demands for increased and better services. In order to adequately address the needs of our growing senior community, we must assiduously plan in advance of this growth to design a system of care that will be of the highest quality, adequately financed and founded in humanity and compassion.

The Special Committee on the Elderly was established in September of 1986 to create a legislative framework that would enable the elderly to remain healthy, independent, and active members of our community. As a result of this Committee's work, the following comprehensive package of referrals was developed to provide the County Legislature and the County Administration with a useful guide in carrying out their responsibilities to initiate changes that will remove gaps in senior services and improve the quality of life for our older citizens.

The specific legislation in this package addresses the following issues and concerns:

- Nursing Home Bottlenecks
- Home Health Care
- Home Health Aides
- Home Maintenance Programs
- Family Respite
- Expanded In-Home Services for the Elderly
- Housing Options
- Housing Development
- Continuing Care Communities
- Transportation
- Additional Bus Routes Between Suburbs
- Door-to-Door Wheel Chair Service
- Innovative Health Preservation Programs
- "Brown Bag" Medication Program
- Sensitivity Training
- Home Health Professional Shortage
- Mobile Intervention Unit
- Mental Health Services
- Recreational Programs
- Volunteerism
- Long Term Care
- Emergency Response System
- Standing Sub-Committee on Aging

Given the importance of preserving the comprehensive nature of this proposal, we encourage the Legislature to review it as an universal package designed to improve the quality of life for our senior community. We believe that, in its entirety, this package will be a significant step in addressing the needs of the fastest growing and most deserving segment of our County's population - our older citizens.

Please refer this matter to the appropriate committee(s).

Sincerely,

Joseph D. Morelle
Assistant Majority Leader
Legislator - 16th District

Frederick J. Amato
Vice President
Legislator - 8th District



Monroe County Legislature

900643

JOSEPH D. MORELLE
LEGISLATOR - 16th DISTRICT
370 LAURELTON ROAD
ROCHESTER, NEW YORK 14609
RES. 716-988-7991
BUS. 716-488-5040

ASSISTANT MAJORITY
LEADER

COMMITTEES
Vice-Chairman:
Agenda/Charter
Planning & Economic
Development

May 22, 1990

To the Honorable
Monroe County Legislature
39 W. Main Street
Rochester, New York 14614

Re: Door-To-Door Wheelchair Service

Honorable Legislators:

A continuing problem for Monroe County's frail elderly has been the limited availability of door-to-door wheelchair service which keeps many residents housebound.

Therefore, we are requesting that the county target any new transportation resources to programs serving the frail elderly who require door-to-door wheelchair service. We are also requesting the current status of door-to-door transportation programs and resources for same.

Please refer this matter to the appropriate committee(s) for consideration.

Sincerely,

Joseph D. Morelle
Assistant Majority Leader
Legislator - 16th District

Frederick J. Amato
Vice-President
Legislator - 6th District



Monroe County Legislature

900642

JOSEPH D. MORELLE
LEGISLATOR - 16th DISTRICT
370 LAURELTON ROAD
ROCHESTER, NEW YORK 14609
RES. 716-388-7121
BUS. 716-435-2040

ASSISTANT MAJORITY
LEADER

COMMITTEES
Vice-Chairman:
Agenda/Charter
Planning & Economic
Development

May 22, 1990

To the Honorable
Monroe County Legislature
39 W. Main Street
Rochester, New York 14614

Re: Creating Additional Bus Routes

Honorable Legislators:

A major problem for the elderly in Monroe County is the lack of public transportation routes between county suburbs.

Therefore, we request that Monroe County work with the Genesee Transportation Council and the RGRTA to investigate the feasibility of creating additional bus routes between county suburbs and report to the Legislature on these deliberations.

Please refer this matter to the appropriate committee(s) for consideration.

Sincerely,

Joseph D. Morelle
Assistant Majority Leader
Legislator - 16th District

Frederick J. Amato
Vice-President
Legislator - 6th District



Monroe County Legislature

900641

JOSEPH D. MORELLE
LEGISLATOR - 8th DISTRICT
370 LAURELTON ROAD
ROCHESTER, NEW YORK 14609
RES. 716-886-7921
BUS. 716-488-8040

ASSISTANT MAJORITY
LEADER

COMMITTEES
Vice-Chairman:
Agenda / Charter
Planning & Economic
Development

May 22, 1990

To the Honorable
Monroe County Legislature
38 W. Main Street
Rochester, New York 14614

Re: Coordination of Transportation for Seniors

Honorable Legislators:

During many public meetings held by the Special Committee on the Elderly, residents repeatedly brought up their frustration with transportation services.

We, therefore, request that the Monroe County Office For the Aging report on efforts being initiated between the United Way, Medical Motor Service, Genesee Transportation Council and the Rochester Rehabilitation Center on the coordination of vehicle scheduling, and specifically the purchase, maintenance and dissemination of information by transportation providers and project sponsors.

Please refer this matter to the appropriate committee(s) for consideration.

Sincerely,

Joseph D. Morelle
Assistant Majority Leader
Legislator - 18th District

Frederick J. Amato
Vice-President
Legislator - 6th District



Monroe County Legislature

40063k

JOSEPH D. MORELLE
LEGISLATOR - 16th DISTRICT
370 LAURELTON ROAD
ROCHESTER, NEW YORK 14609
RES. 716-380-7521
BUS. 716-438-3040

ASSISTANT MAJORITY
LEADER

COMMITTEES
Vice-Chairman:
Agriculture/Charity
Planning & Economic
Development

May 22, 1980

To the Honorable
Monroe County Legislature
39 West Main Street
Rochester, New York 14614

Re: Emergency Response System (ERS)

Honorable Legislators:

In the last ten years, the number of frail elderly, aged 85 and over increased by 48 percent in Monroe County. Nationally, Census figures indicate that the number of people over the age of 90 will increase 236 percent to a total of 1.9 million by the year 2000. The biggest fear of our very old, is that they would need medical attention and would not be able to call for help.

The Special Committee on the Elderly learned and recognized the value of a countywide emergency response system through a series of public hearings held to enable seniors to give their views on how their concerns can best be addressed. A countywide EMS would be an alarm device worn by at-risk, frail elderly who live alone, and which could be sounded in times of medical emergency. Sounding the device would activate a response from the nearest hospital or medical center.

Ideally, funding would be provided through the county budget, private grant foundations, service organizations, and user fees. Contributions from the users would be based on financial need. We request the Administration investigate the concept of a countywide EMS and report their findings to the legislature.

Sincerely,

Joseph D. Morelle
Assistant Majority Leader
Legislator - 16th District

Frederick J. Amato
Vice-President
Legislator - 6th District

Ms. SLAUGHTER. We certainly do thank you.

That completes our witness list. Congressman Downey wanted me to tell you as well how much he appreciated being here today. He is out this afternoon visiting some of the centers that we have been talking about this morning, because we do like to show off what we are doing up here.

Let me tell you, particularly since he is not here, and I am in charge for the moment, that I think this area does a better job and does it with more commitment and does it with more imagination and can do more with fewer resources than probably any place in the country. All I can think about this morning as I hear all of you who are providers and clients and workers, is that if we gave you just a little more, that you could reach out and really meet the needs of the people in this community. It is really important that those of us who serve in Congress carry that message back to Washington. The good stewardship that you have already given to the amounts of money that you get, the miracles that you worked with this money provide an important lesson as we look ahead to meeting the needs of a growing elderly population. Your experiences prove that we must change some of the priorities in this country and put more money back into the American people and into our human infrastructure.

I thank all of you very much for coming. And without objection, I would like to include in the record the testimony of Dr. Forsyth. This hearing is now adjourned.

[See Appendix, p. 150, for material submitted by Dr. Forsyth.]

[Whereupon, at 1:44 p.m., the hearing was adjourned.]

APPENDIX

Assemblyman Paul Harenberg
Chairman - Assembly Standing Committee on Aging
New York State Legislature
Legislative Office Building, Rm. 724
Albany, NY 12248

Testimony for the Field Hearing of the Older Americans Act
in Rochester on Monday, June 11, 1990

Thank you for the opportunity to present comments from the perspective of the New York State Assembly Committee on Aging on the unfunded programs under Title III of the Older Americans Act.

As our older population grows rapidly in numbers toward the twenty-first century the need to provide services and access to services for the elderly also grows rapidly.

The insight of those that initiated the Older American Act twenty-five years should be acknowledged once again. As we know so many of the social programs developed in the sixties came into hard times in funding during the eighties. Many very good programs no longer exist, and many more continually fight for their existence. The eighties are over, and during the nineties we must give priority to those programs that give quality of life to those in need.

The 1987 reauthorization of the Older Americans Act required states to establish minimum funding levels for legal services, in-home services, and access services. From the perspective of the Assembly Committee on Aging, our greatest concern is the growing burden that is placed on the State of New York to fund very worthy programs without the continuing support of the federal partnership. Statistics provided to us from the State Office of the Aging indicate that the State share of financial support continues to increase at a much more rapid pace than the federal share; in 1989 the federal share increased by 7.43% while the State and local share increased by 51.33%.

The economic growth of New York has slowed drastically this past year. The effect of that slow down on social programs is very profound and will affect elderly programs. Tough financial decisions are being made at every level of government. We need the programs offered by the 1987 amendments of the Older American Act and adequate funding to support the continuation of the programs once they are put into operation. Yet as important as these amendments are, they should not displace funding for current programs that are effective and meeting crucial elderly needs.

The need to reach potential SSI recipients through Outreach programs, transportation to health related and other services, Alzheimer's diagnostic programs and support services for families, legal services for potential Medicaid and food stamp

recipients, more and better trained ombudsman services for those that cannot represent themselves, and the growing issue of elder abuse are some of the issues that advocates lobbied for this year. Unfortunately I had to tell these advocates that the money was not available in the State of New York to either fund the start up of new programs or to expand existing programs to the degree needed to meet the needs of the potential client within their community.

Many advocates spent time in my office this year asking for an increase in the State subsidy for SSI in order to raise the SSI payments to poverty level. A public hearing was held in New York City that stressed the plight of those "attempting" to live on SSI. This is a very important issue, but equally, or more important, is the need for an Outreach program to reach those individuals eligible for SSI and not receiving the service. More federal money is needed to support and expand the existing projects. The existing Outreach programs that provides access to SSI Medicaid eligibility, legal services, etc., are "under programmed" in terms of staff time, availability and financial resources.

Elder Abuse is a growing concern. While we, in New York State, do not have mandatory reporting, we must have the public education, the outreach to identify and report incidents of abuse and the support services to deal with abusive and potential abusive situations.

Quality, affordable health care is a subject that is on everyone's agenda for all ages, as it should be. Preventive care through education, routine health screening, nutritional counseling, and adequate physical activities are some of the components of health care that were part of the 1987 amendments to the Older Americans Act. Our elderly are enjoying better health for a longer period of time. This is due in large part to a change in lifestyle through education. We must continue to provide preventive health services because the alternative of caring for the sick is just too expensive with our present medical system.

Access to services for senior citizens has been made possible through the Area Agencies on Aging, funded by the Older Americans Act. Seniors feel good having access to an agency that acts as a network to assist them in obtaining their needs. I urge the continued increase in funding for this very important component of senior services while continuing to work toward strengthening information and referral systems, outreach efforts, benefits counseling, and public education.

I look forward to a cooperative effort of federal and state responsibilities in working toward quality of life for our aging population.

NEW YORK STATE OFFICE FOR THE AGING

Mario M. Cuomo, Governor

2 Empire State Plaza, Albany, NY 12223-0001

Jane G. Gould, Director



RECEIVED

JUN 22 1990

June 18, 1990

Cong. Thomas J. Downey

Honorable Thomas J. Downey
U.S. House of Representatives
Washington, D. C. 20515

Dear Congressman Downey:

I would like to thank you once again for the opportunity to submit testimony on the subject of "Older Americans Act: Health Promotion and Education and Other Unfunded Programs." I regret that a prior commitment kept me from personally presenting the testimony in Rochester. I am certain, however, that your staff and mine will be communicating quite often as the time for the Act's reauthorization draws near.

I am enclosing a copy of the testimony submitted by this Office for a hearing held recently in Philadelphia by the Administration on Aging. It provides information that you may find useful, particularly on the economic commitment of New York State to Older Americans Act Programs and Older Americans Act-type programs.

In the coming months, I will continue to provide you with information pertinent to the Act's reauthorization. With your continued leadership, I am certain the Older Americans Act will be more effective than ever.

Sincerely,

Jane G. Gould
Jane G. Gould

An Equal Opportunity Employer

1-800-342-9871 Senior Citizens' Hot Line Call toll-free for information about local programs and services

NEW YORK STATE OFFICE FOR THE AGING

Mario M. Cuomo, Governor

2 Empire State Plaza, Albany, NY 12223-0001

Jane G. Gould, Director



TO: Dr. Joyce T. Berry, Commissioner
Administration on Aging

FROM: Jane G. Gould, Director
New York State Office for the Aging

SUBJECT: Older Americans Act Reauthorization

DATE: April 24, 1990

I thank you for this opportunity to comment on the 1991 reauthorization of the Older Americans Act, which will observe its Silver Anniversary this year. Conceived and enacted at a time when idealism was at a high point, the Older Americans Act of 1965 paved the way for the creation of nutrition programs, supportive service and many other programs intended to improve the quality of life for our senior citizens. The successful implementation of these programs are testimony, indeed, to this country's continuing commitment to the health and well-being of its aging population.

No doubt you have heard, and will hear again, testimony on how, over the years, various programs have met the needs and requirements of older Americans. Those of us in the aging network certainly can look back over the past 25 years and take pride in what has been accomplished; yet, we must always remember there are still issues to address and still much to be accomplished in this

An Equal Opportunity Employer

1-800-342-9871 Senior Citizens' Hot Line Call toll-free for information about local programs and services

last decade of the twentieth century. A reminder of this is found not in looking to the future, but by looking back to 1987.

The 1987 reauthorization of the Older Americans Act required the states to establish minimum funding levels for legal services, in-home services, and access services. These provisions advanced the community based care and elder rights needs of our senior citizens. 1987 also saw the strengthening of the State Long Term Care Ombudsman Program to advocate on behalf of older residents of long term care facilities. In many ways then, the initiatives and mandates of the 1987 reauthorization added to the legacy of the Older Americans Act.

Yet, there are many programs and initiatives that were included in the 1987 reauthorization that received little or no funding. These programs and initiatives include elder abuse, outreach, health promotion, unmet needs, and the then new Title III-D In-Home Services for Frail Older Individuals. It is true that some of these programs, despite funding problems, were carried out at the state and local level and still managed to enjoy some success. The previously referred to ombudsman program is particularly worthy of note in this respect. Yet, the fact remains that there is still much to be done and it will have to be done at a time when Federal, state, and local programs find themselves competing for limited, if not diminishing, resources.

In Federal Fiscal Year 1986, the Federal government contributed \$46,126,000 to Title III programs in New York, while the State and local share amounted to \$22, 538,000. In FFY 1989, the Federal share was \$49,555,000, an increase of 7.43%. The State

and local share of these programs, meanwhile, increased by 12.03% to \$25,250,000. However, when other State and local programs for the elderly are considered - programs such as Community Services, Supplemental Nutrition Assistance Program for the Frail Elderly, and Expanded In-home Services for the Elderly Program - an even more staggering picture emerges.

In FFY 1986, Federal, State and local governments spent \$89,063,208 on Title III and similar service programs for the elderly in New York. The State and local share for these programs for the elderly amounted to \$42,937,208, just over 48% of the total spent. By FFY 1989, the total spent on Title III and similar service programs for the elderly increased to \$114,536,170. As already noted, the Federal share increased by 7.43%. The State and local share increased by 51.33%, to \$64,981,170.

The figures cited here are for New York alone. Other states may very well have similar stories to tell. The states have shouldered their share of the burden and more over the past few fiscal years. Many states now face tough times as their economic growth slows down. We will be hard pressed to keep pace with the increasing demand for services.

It has been suggested by some that in a time of stagnating economies, we should be content with funding existing programs at current levels plus yearly increases that reflect the annual rate of inflation. According to this theory, there is just so much funding for just so many programs. Now is the time to maintain the status quo. But what does it mean to maintain the status quo?

What is the status quo for the daughter or daughter-in-law

who is caring for an elderly parent? What is the status quo for the husband or wife who cares for an elderly, incapacitated spouse at home? What do you tell them when they find they are in need of respite, of programs that would allow them to take a much needed break? Existing programs barely meet the need. If anything, we can expect the number of such care givers to increase over the next several years. Who will tell those care givers: "You will have to be content with the status quo, because we cannot find the means to support more adult day care and respite programs."

What happens when that parent or an elderly spouse can no longer be cared for at home? Who will be the one to say: "I'm sorry, but you will have to go into a facility that is many, many miles away from your home. I know it will be difficult for your family to visit you, but we just did not have the means to establish a community based long term care system."

What do you say to the family of an elderly spouse or parent when they find they will not be able to visit the nursing home because they can't drive, and there is no public transportation? Who will be the one to say: "I'm sorry, but we didn't have the means to fund new senior centers or programs that may have supported a transportation service you could use now."

It is not just the incapacitated and their families that will be affected if we merely maintain the status quo. What about the senior citizen who seeks employment and is denied a job because of age? It doesn't matter why the job was sought, whether it was for financial reasons or simply for the joy of working. What matters is that the denial was simply on the basis of age, rather than the

ability of the person to do the job.

What about the elderly couple who faces the loss of their apartment because the landlord decides he wants to raise the rent to a level they can't afford, or because he simply prefers to rent to a younger couple?

What about the older person who is in need of medical treatment or prescription drugs, but doesn't seek it because of the cost, and because no one ever attempted to explain the benefits that are available through various programs?

What about the nursing home resident who wants to comment on the quality of the food served at the long term care facility but won't because of fear of reprisal?

Who will tell these elderly citizens - the job seeker, the tenant, the medically needy, and the nursing home resident - that we couldn't find the means to support a legal assistance program for the elderly, or an out reach program or a benefits counselling program, or an ombudsman program at a level that would allow these programs to keep pace with the need?

I have gone on at some length describing different events that could happen to different people. I know you are looking for specific recommendations for the 1991 reauthorization. I recommend we seek reauthorization and funding for all existing programs, including those not funded following the 1987 reauthorization. We should avoid the sham of supporting a program or demonstration project that has little or no chance of being funded.

I have several other recommendations I would like to also offer at this time.

Period for Reauthorization: Reauthorization should be for a period of at least four years. The continuity and stability of services and programs authorized by the Older Americans Act would be jeopardized if reauthorization were sought for a lesser period.

Funding Increases: We need to seek funding increases at a rate that is set to realistically reflect the needs of a rapidly growing vulnerable population. An increase based on the rate of inflation, as noted before, will barely be enough to maintain the status quo. The status quo is not acceptable.

New Programs: On a related matter, new programs should not be funded at the expense of existing ones. There is no question that there are new services and programs than can be, and should be, offered to our senior citizens. Nonetheless, new programs should carry with them a separate authorization of funds to guard against disruption of current services.

Cost Sharing: This is an idea whose time has come for services such as home care, adult day care and meals. A sliding fee scale could be utilized, but it should be a scale based only on the income of the elderly recipient of services, without regard to other familial resources. The elderly recipient should not be forced to go through an onerous means testing. The sliding fee scale should also take into account the housing costs of the recipient of services, and offset them accordingly. It must be made clear at the outset, however, that the funds raised through cost sharing will be used to enhance the service delivery. Ability to pay must not be a factor in determining who gets services and who does not. Those who are unable to pay must not be given a lower

priority than those who can.

Voluntary Contributions: While I support the concept of cost sharing, I also strongly support the continuation of the solicitation of voluntary contributions. It has long been recognized that having the opportunity to make contributions is important to the recipient of services. It oftentimes is essential to maintaining a sense of self-esteem. Again, the ability, or even the willingness, to contribute must not be made a condition for the receipt of services.

Federal Council on Aging: It is time to re-evaluate the need for this entity. If it is to continue, the Council must become more active than it has been in the past decade.

Leadership: Under Title II, the Administration on Aging should exert more of a leadership role and become a highly visible and effective advocate. This is not to fault the Administration on Aging for its past efforts. In light of the competition for diminishing resources, however, it is imperative that the maximum effort be made, from the top on down.

State Units on Aging: State Units should continue to have the primary responsibility for planning, policy development, priority setting and evaluation of OAA activities within their respective states. This would include primary responsibility for the coordination and integration of services to meet the long term needs of older persons.

Nutrition Programs: I support the continuation of the current OAA provisions that allow transfers of up to 30% in funds between social or supportive services (Title III-B) and nutrition services

(Title III-B). I also support continuing the authority, within Title III-C, to make transfers between C1 (congregate meals) and C2 (home-delivered meals).

Minorities: It is time to develop amendments to strengthen the authority of state governments, through their respective State Units on Aging, to ensure that funds are targeted to low-income minorities. Area plans should be required to show how allocations of funds within the planning and service area will be utilized to serve the needs of this target population. State imposed sanctions should be authorized, including, but not limited to, recoupment and withholding of funds.

Community Care Programs: State Units On Aging, along with Area Agencies on aging, should be encouraged to take the lead in the design and establishment of community care programs. The input of older persons, community leaders, and state officials should be sought and given all due consideration. Community care programs offer a unique opportunity to draw upon the strengths of existing service systems - federal and state, public and private.

Access: The best designed programs, the most well-intentioned and beneficial of services, are of no avail to the senior citizen who cannot benefit by or receive them. We are aware that there are still barriers which act to deny services to those who most need them. We must ensure access to programs and services by strengthening information and referral systems, outreach efforts, escort services, benefits counseling, and public education.

In addition to the above comments, I would also like to make the following suggestions:

- o Strengthen those programs, such as the Legal Assistance and Ombudsman Programs, that advance the elder rights of senior citizens;
- o Emphasize the public purpose nature of the State and Area Agencies on Aging and how the private sector can benefit from programs for the elderly;
- o Encourage, perhaps through grants programs, participation by the private sector in programs for the elderly;
- o Strengthen the ability of State Units on Aging to coordinate employment activities;
- o Allow parallel eligibility for both Title V and JFPA so that if a person is eligible for one program, he or she would automatically qualify for the other;
- o Study the possibility of applying funds freed up by the "peace dividend" to new or expanded programs for the elderly.

As I said before, we can look back on the past 25 years with pride at what has been accomplished. Yet, I am reminded of the words of Lord Tennyson's Ulysses who said,

"Old age has yet his honor and his toil;
Death closes all; but something ere the end,
Some work of noble note, may yet be done."

I suggest to you that there are still challenges that lie ahead, issues we must yet address, and some work of noble note yet to do so that the elderly, those in old age, may be treated with the honor and dignity they deserve. With continued interest in the Older Americans Act and advocacy on behalf of older Americans, I

am confident that 25 years from now we will look back with pride
at having met those challenges and addressed those issues.

Thank you.

cc: Mrs. Judith Rackmill
Mr. Paul E. Ertel, Jr.



THOMAS R. FREY
COUNTY EXECUTIVE

KATHERINE LEWIS
ADMINISTRATOR
716-276-7880

Testimony for Congressional Field Hearing
Reauthorization of the Older Americans Act
June 11, 1990
Rochester, New York

Katherine J. Lewis, Administrator
Monroe County Office for the Aging

I am very pleased, Congresswoman Slaughter and Congressman Downey, that this Congressional panel has come to Rochester, New York in order to hear this community's thoughts on reauthorization of the Older Americans Act, and in particular of the currently unfunded sections of Title III. I commend you for your interest and your willingness to go out to communities.

As Administrator of the Monroe County Office for the Aging, I would like to share my thoughts on the current needs for services funded under the Older Americans Act. The Monroe County Office for the Aging (MCOFA) administers a budget of over \$4 million annually, distributing dollars to many non-profit organizations throughout the community to provide the wide variety of services so necessary to keep many older persons healthy and independent. Approximately half of the MCOFA budget comes from federal Older Americans Act dollars. Over 122,000 persons over the age of 60 live in this County, which includes the urban area of Rochester, as well as suburban and rural areas. I believe that the payback in avoided medical and custodial care costs, were it able to be calculated, would be a hefty multiple of the Older Americans Act dollars invested.

The unfunded sections of the Older Americans Act contains may very important elements--health screening, exercise, Ombudsman funding, elder abuse prevention services and more. You have heard much testimony today about the value of these programs to individuals and to the community. Currently some communities have found ways to provide certain of these services; some have not.

I would submit to you that what our community, and I believe others as well, most needs is a substantial increase in Title IIIB of the Older Americans Act. This Title allows us to expend dollars on all of the services outlined in the unfunded programs, yet also gives us the flexibility to place dollars where they are most needed. If, for example, a local hospital is already conducting extensive health screening in senior centers and other locations, additional dollars could be better spent in covering unmet needs. Language could be included urging communities to insure that services outlined in the unfunded Title III sections are available to older Americans.

One of the barriers to providing effective service delivery is complexity of funding regulations, requiring separate contracts, tracking and reporting systems. I believe the goals of the Congressional authors of the very important programs described in the unfunded sections would be best met by a substantial increase in Title IIIB.

Thank you for your interest.



FINGER LAKES LONG TERM CARE
INSURANCE CO.

June 21, 1990

Ms. Louise Slaughter
311 Federal Building
100 State Street
Rochester, New York 14614

ATTN: Linda Donahue
RE: Older Americans Act Testimony

Dear Ms. Slaughter:

We are pleased to have the opportunity to submit testimony on the Older Americans Act.

Once again, we compliment you and your staff for developing programs to serve the elderly and to bring visibility to the problems of the elderly facing Long-term Care.

Do not hesitate to contact me at (716) 238-4433 if we can provide additional information.

Sincerely,

Gay M. Pollock
Gay M. Pollock
Director, Long-Term Care

ATT.

xc: H. Berman
D. Klein

STATEMENT OF

FINGER LAKES LONG TERM CARE INSURANCE COMPANY

TO THE

SELECT COMMITTEE ON AGING

SUBCOMMITTEE ON HUMAN SERVICES

Regarding

~~LONG-TERM CARE INSURANCE~~

under the OLDER AMERICANS ACT

June 22, 1990

Rochester, New York

Finger Lakes Long Term Care Insurance Company commends the Select Committee on Aging Subcommittee on Human Services for examining how the Older Americans Act can better address the needs of senior citizens. We are presenting comments that the New York State Conference of Blue Cross and Blue Shield Plans delivered to the New York State Assembly Standing Committee on Insurance, the Assembly Standing Committee on Aging, and the Assembly Standing Committee on Health on November 20, 1989; and which were reiterated in testimony given on January 30, 1990, in Albany, New York.

We believe that long-term care insurance is an important insurance product which will increasingly be viewed as an integral part of retirement planning, along with pensions, social security, and Medicare and Medigap insurance.

Finger Lakes Long Term Care Insurance Company was formed in 1987 as a wholly owned subsidiary of Blue Cross and Blue Shield of the Rochester Area. We have been actively engaged in marketing our product since that time, and have expanded our product line to include sales to groups in order to broaden the base of policyholders. As a result of our extensive activity, we have quite a bit of information which we hope will be useful to you in your deliberations.

1. The Scope of Coverage Offered by Finger Lakes Long Term Care Insurance Company.

It is important to begin by noting that our corporate objective in entering the long-term care insurance market has been, and continues to be, to develop the most comprehensive long-term care insurance products in the marketplace. We have very deliberately included coverage of both home care and nursing home stays, and custodial care as well as skilled and intermediate level care. We also cover adult day care and alternate level of care in the hospital. In addition, we have avoided the use of any requirements of a prior stay in a hospital or nursing home in order to obtain benefits from our company.

We offer coverage of 3 years of nursing home care, and 5 years of nursing home care.

There are several features which distinguish our long-term care insurance from other products in the marketplace.

The first is our managed care and patient advocate program. In order to avoid inappropriate utilization of long-term care services simply because insurance coverage is available, we have developed a benefits management group. The benefits management group consists of trained health care professionals who are employed by us and who evaluate the specific service needs of each individual person at the point

when they need long-term care. In order to obtain benefits the patient or their family member calls our benefits management group. We then evaluate the patient's cognitive, behavioral and functional abilities and the most appropriate level of care and array of services is then selected.

In addition, the benefits management group is also available to act as a patient advocate even for services that we do not cover. For example, while our program does not pay for meals-on-wheels, if a policyholder does not have a family member with the time or ability to make arrangements for meals-on-wheels our patient advocate will act on the person's behalf (at their request, of course) to make the necessary arrangements for the meals to be delivered.

Another special element of our program is that premium payments can be made monthly in the usual fashion or they can be made over a limited term of either 10 or 20 years. If the premiums are paid on a 10 or 20 year term basis, then the policy is paid up at the end of the term and no further premium payments need be made for the remainder of that person's lifetime. We anticipate that this feature will be particularly useful for retirement planning. For example, an individual who is age 55 could buy our long-term care policy now and select the 10 year paid up option. They would then pay premium payments for 10 years until they are age 65. At the time they retire their long-term care benefits would be

fully paid up, and no future premium payments would need to be made.

We do conduct underwriting reviews of applicants who apply for our coverage and there is a six-month waiting period for pre-existing conditions.

2. The Need for Federal Tax Credit.

We have been marketing our long-term care insurance (in the upstate area) for almost two years. We have learned quite a bit about what it takes to convince people of the need to plan for and protect against the costs of long-term care. It is, of course, very easy for those of us in the insurance industry and for policymakers to talk about the need for long-term care insurance. But it is quite another matter to convince Mr. and Mrs. Jones that they lack adequate coverage for long-term care and that the expense of a high quality long-term care insurance policy is a worthwhile investment of their monies.

The first thing we have learned is that it is more difficult to sell long-term care policies than anyone expected. Our extensive market research had convinced us that the sales effort would be difficult, and it was therefore surprising that it turned out to be even more difficult than even our initial expectations.

The toughest part of selling long-term care insurance is the consumers' lack of awareness of their current coverage and understanding the risks and costs they face. For example, a tremendous proportion of the population thinks they are covered for long-term care insurance right now. They do not realize the very limited extent of Medicare coverage for long-term care services, particularly custodial care services. Unfortunately, the enactment of the federal Medicare catastrophic program convinced even more people that they were in fact covered and did not need private long-term care insurance. Perhaps the controversy and repeal of the Medicare catastrophic program will change that attitude, but we are not sure.

Other consumers know that they are covered but believe, or want to believe, that government will soon enact a program for long-term care. People who hold this view are obviously unwilling to pay premiums for private long-term care insurance.

Our conclusion is that consumer education is a most important activity at the present time, both by insurers and government. Therefore we are engaged in extensive consumer education activities.

A second problem insurers have encountered is that quality long-term care services are expensive, and therefore, by definition, quality insurance for the long-term care can not be cheap. For example, premiums for our policy with three years of long-term care benefits which is issued to a person aged 65, with a 20 day waiting period before benefits are available in a nursing home, and where premiums are paid monthly for life, is \$93.50 per month. If a husband and wife both purchase a policy then the monthly cost is doubled to be \$187.00 per month.

On those occasions when we are successful in convincing people that they do not now have adequate protection for long-term care services, some people decide that they would prefer a rather inexpensive policy which does not provide significant coverage for long-term care services. In that instance we end up having performed the important function of educating the consumer, but we lose the sale. More importantly, the consumer may think they have obtained substantial protection but in fact they have not. This is where consumer education is vital because the confusing lingo (skilled v. custodial care, etc.) sometimes causes bewildered consumers to buy a policy which covers only skilled care when in fact custodial care is more commonly needed.

Something bold and direct is necessary in order to stimulate sales of high quality long-term care insurance in a marketplace where there is great confusion about the coverage provided by federal programs, and where many consumers may be misled by low cost policies which provide no genuine protection.

We are convinced that a federal tax credit is that necessary initiative. This is true for two reasons. First, the tax credit would reduce the out of pocket costs for the insurance. This is vital because the public is only protected if they have high quality coverage. A tax credit will encourage the purchase of the higher quality, higher coverage policies that many people desire. Second, a tax credit would also lend credibility to the true, but largely unacknowledged, fact that federal programs do not now provide significant coverage for long-term care services.

The New York State Conference of Blue Cross and Blue Shield Plans worked with Rochester area Assemblyman Roger Robach, and Senator Lombardi, late in the 1989 session of the Legislature to introduce legislation providing such a New York State tax credit. (The bill is New York State Assembly Bill 8421 and New York State Senate Bill 5370.) The bill provides a 20% tax credit to persons who purchase a qualified long-term care policy. In order for a policy to qualify for the tax credit the legislation provides that the policy must

include coverage for a minimum of three years of long-term care services. It must cover home care as well as nursing home care. It must cover custodial as well as skilled and intermediate care, and the benefit payment must be a minimum of either \$60 per day with inflation protection to double that to \$120 per day within 20 years.

Any incentive to stimulate sales of policies must have an immediate and economically significant effect on the prospective purchaser. There are, of course, many possible types of incentives, but only incentives which will convince significant numbers of people to actually commit to the expense of a policy are those incentives which have an immediate impact and will offset the current outlay funds necessary to purchase the policy. A tax credit base meets those requirements.

Our initial research indicates that the savings to the New York State Medicaid program due to increased private sector long-term care insurance would far outweigh the revenues lost due to the tax credit. However, the New York State Legislature may wish to limit a tax credit to policies purchased in the next 5 or 10 years. We present these ideas for consideration at the federal level.

We urge that any tax credit legislation focus all the tax credit monies in the consumer rather than the insurer. The stimulus that is needed is to make the public aware of their need for such insurance and to make such coverage more affordable, using a tax credit. If the demand for the product exists the insurers are ready and willing to sell the coverage. Therefore the tax credit should not be geared to the insurers themselves but rather to consumers who, after reviewing the available products in their region and price range, decide that they want to purchase long-term care insurance.

3. The Regulatory Environment.

We have found that the New York State Insurance Department has been very receptive to listening to ideas about new long-term care products, and they have been very willing to offer their suggestions on where policies could be improved to provide better benefits to consumers. The Department should be complimented for their devotion of significant time and effort to facilitating the introduction of long-term care policies.

We compliment the Select Committee on Aging for facilitating information discussion at the federal level.

4. Summary.

In summary, we have been very pleased to enter the long-term care insurance market and we feel that over the long haul it will prove to be a good market where the public obtains valuable insurance protection and the insurers succeed by meeting that need. However, the process of convincing the public that they lack adequate coverage for long-term care services should not be underestimated and a federal tax credit would lend both affordability and credibility. The importance of promoting the purchase of good quality coverage, rather than skimpy coverage which simply has an attractive premium rate, must be consistently reiterated.

If not, the expansion of long-term care insurance will be an empty promise whose hollow core will be discovered years from now when today's purchasers begin to receive long-term care services.

Thank you very much for receiving our comments. We would be pleased to answer any questions you might have.

Gay M. Pollock
Director, Long-Term Care
June 21, 1990

William B. Forsyth, M.D.
34 Woodbury Way
Fairport, New York 14450

Presentation to the Field Committee on Aging Subcommittee on Human Services June 11 in Rochester, New York.

I am a retired physician with background in pediatrics, Health regulation of medicaid and nursing homes, Occupational medicine, and HMO medical direction. I am currently the medical director on a part time basis of three local nursing homes. I am making this presentation as the representative of the Monroe County Medical Society on the Health Advocacy Board. My comments are my own opinions and not those of the Medical Society although they have agreed with and supported our actions to date.

I believe that the amendments to the Older Americans Act proposed by Congresswoman Slaughter will offer needed services to the elderly who face a bewildering array of choices and promotions for health care coverage. The duplications of coverage which may take scarce income dollars from those with marginal incomes severely impact on the quality of life and force the use of public funds for neglected health and housing needs should be stopped. I have read the proposed amendments and feel that if they are passed and implemented to insure a viable volunteer effort with minimal professional staff support with sponsorship by local community groups they will be highly effective.

I have shared my copy with the Monroe County Medical Society. While they have not had time to formally review it, I have been told that the society does agree with the goals expressed in the proposed amendments.

I am enclosing a brief history of our project and five vignettes from our counselors for your information and understanding of our program. Thank you.

June 11, 1990
William B. Forsyth, M.D.

THE HEALTH ADVOCACY PROGRAM

A Community Sponsored Medicare Program for Persons with Health Insurance Related Problems

The Medicare Medicaid Assistance Program is sponsored by the Monroe County Medical Society(MCMS), the American Association of Retired Persons (AARP) and the Monroe County Office for the Aging (MCOA) to assist persons with health insurance problems.

The program which is in operation in 15 locations in our area began in 1988 when the Monroe County Medical Society recognized that many physicians devote a good deal of time to keep up with changes in medical technology and find it difficult to stay informed about the latest Medicare rules. The Society assumed that Medicare beneficiaries experienced similar problems and agreed to sponsor a program to help those individuals with Medicare claims and billings. The AARP which has an extensive Medicare counseling program for Medicare enrollees who have billing problems was contacted. They were most cooperative and agreed to bring the program to Rochester as co-sponsors with the Medical Society.

In the first phase of the program letters were sent to Rochester Industries in an effort to recruit a group of retirees who might be interested in helping to establish the program and serving as volunteer counselors. The group met first in June 1988 and has enthusiastically worked to bring the program to Rochester. In July 1988 the group was joined by the Monroe County Office for the Aging as co-sponsors. The first task was to survey Rochester agencies to assure the need for counseling service. Once the need was established the AARP three day training course for the volunteer counselors was scheduled. There were 48 persons who volunteered to serve as counselors and were trained on November 29, 30 and December 1st 1988.

Since then a cooperative presence has been established with a number of Rochester agencies to permit on site counseling on a by appointment basis. The sites are located throughout Monroe County.

Any Medicare beneficiary who is experiencing difficulties in filling out Medicare forms, or who has received a rejection of payment notice from Medicare or who is having a problem with his or her Medicare claim may seek counseling and assistance from trained volunteers. Those individuals who may also be eligible for further help through Medicaid will be referred.

Individuals desiring assistance should call (716) 274-7810, the hotline established by the Monroe County Office for the Aging. The person receiving the hotline call will contact a trained volunteer in the caller's locality who will contact the person who placed the assistance request and seek to resolve the problem. If necessary an appointment will be made to discuss the problems at a counseling site. Where a person is homebound because of illness a home visit can be arranged. There is no fee for this service.

Information posters and brochures have been distributed to physician's offices, hospitals, pharmacies, libraries, churches and senior clubs. An increasing number of calls are being received. We are encouraged by those we have discussed the program with and by the response of those who have called on us.

The current success of the program is the result of the close cooperation of the three cosponsors. The support of the Monroe County Office for the Aging through the provision of staffing for the hotline has been a major help. The use of the Medical Society mailing files to expedite the continuing mailings so necessary to establish a recognized community presence has also been essential.

The curriculum support and provision of teaching aids and literature by the AARP has made the continued replacement of volunteers possible as well as provided the ongoing training of our active volunteers.

After the initial training expenses were met our operating expenses are minimal and consist of the provision of staff support on a half time basis (MCOA), help with duplicating and mailing (MCMS, MCOA), and provision of teaching material and rental of meeting place (AARP).

To date our active public relations program has continued to bring the service to the public and has resulted in 1420 persons being served within the last twelve months. Vignettes of some of the problems we have been able to help with are enclosed.

As the current changes in the Medicare law which require physician's offices to initiate billing for medicare patients take effect we anticipate we will be called upon to assist in reconsiderations and to help explain the medigap and long term care coverages which are available.

William B. Forsyth, M.D.
34 Woodbury Way
Fairport, N.Y. 14450
(716)-425-3177

June 7, 1990

**Monroe County New York Health Advocacy
Project- Counselor Experience Vignettes**

①

One of our counselors met with a very upset client. It seems the client received a notice that a physician's bill was being sent to a collection agency. She couldn't understand how this could happen and the physician's office was not able to help her. She was covered by Medicare and Medicaid and something like this had never happened before. Step by step the counselor unraveled the mystery. The client needed medical service on a day her regular physician was unavailable. His back-up saw her and referred her to a specialist who was unaware she was a Medicaid patient. After many calls to the physicians' offices, Department of Social Services, Sally Trafton, and Medicare. The counselor's perseverance paid off. The client was cleared of financial responsibility, the physicians were to be reimbursed appropriately and our counselor derived that deep, quiet feeling of satisfaction that frequently follows a Memorable Moment Aiding People.

②

Last winter a M.M.A.P. Counselor discovered and resolved a TEFRA situation and thereby avoided what might have resulted in a financial disaster for a client.

The client worked beyond 65 and recently retired. She should have been told by her employer, three months before turning 65, that upon retirement she could no longer retain her Blue Cross/Blue Shield contract as primary. The employer also was not aware of this situation. The counselor, during casual conversation, discovered this and explained the problem to the client and the employer's personnel representative. Fortunately the situation was resolved in a timely manner. Soon after, the husband was admitted for multiple by-pass surgery. As a very minimum all sorts of delays, appeals and hearings would have been encountered to get this resolved after-the-fact. Also the employer is now aware of his responsibilities in these situations.

**Monroe County New York Health Advocacy
Project- Counselor Experience Vignettes**

A claimant scheduled a meeting with a M.M.A.P. Counselor to review a situation which had become a long-standing frustration.

③

About two years ago the client received two identical services on different days but was reimbursed by Medicare for three. Recognizing the error she contacted Medicare and, at their instruction, cashed the check and returned the total amount on a personal check and included a letter of explanation. She had been told that a check with the proper amount would be issued to her. Over the next 18 months, including 8 phone calls and an additional letter of inquiry to Medicare she received two identical sets of forms to fill out but no check or any correspondence to indicate anyone understood her situation. This past Spring she heard about the M.M.A.P. program and decided to share her problem. The M.M.A.P. Counselor sent a letter chiding Medicare and pleading to have "somebody who can break this mindless recycling of automated communications intercede and have the matter resolved." It was. Within another three weeks she received a check for the proper amount.

④

A friend of a couple in their 80's called the Hotline for help for them. The wife had been homebound for some time, requiring frequent transfusions for anemia and services for various other problems. The husband had been filing their claims, but failing health and a recent stroke and institutionalization now made this an impossible chore. With no relatives to help the couple, and not being familiar with the claims filing process, the young friend learned of our program and decided to call for help. A counselor has been working with them for the past few months sorting bills, E.O.B.'s and filing claims to take care of those within the statute of limitations and bring things up to date. The couple has coverage with Medicare, a basic supplemental insurance, extended benefits with another insurer and a per-diem hospital policy with yet another. It is the counselor's objective to complete the backlog (old statements and E.O.B.'s keep turning up in "files") and then have the friend or a case worker deal with the on-going needs.

**Monroe County New York Health Advocacy
Project- Counselor Experience Vignettes**

A recent widow returned to a counselor for a follow-up appointment for help understanding a E.O.B. She arrived early, and while waiting, overheard bits and pieces as an emotionally distraught recent widower explained to the counselor how much he missed his wife, how she was the one who always took care of their "paperwork". He was comforted by the counselor's ability to help him through his claims problems and, as he was leaving, the waiting client volunteered how she was going through the same adjustment period since her recently deceased husband took care of all of their claims. They began chatting and discovered they both graduated from the same high school and shared some names and experiences from those days. Both gained support from this chance encounter. So you see there can be more to this M.M.A.P. business than claims filing.

○